DRAFT

September 14, 2004

Dear C-CHIP Applicant:

Thank you for your expression of interest in applying to provide services through the County Children's Health Insurance Program (C-CHIP) which is also referred to as AB495.

As you may be aware, many counties in California have implemented or are in the process of implementing their own locally developed children's health expansion program, often referred to as the Healthy Kids Program. These programs generally cover uninsured children at or below 300% of the federal poverty level through the age of 18 regardless of immigration status. These Healthy Kids Programs are usually funded through a variety of sources including First 5 Commissions, health plan reserves, foundations, private contributions, and county funds.

C-CHIP is considered a component of the Healthy Kids Program, but, refers to a group of children whose services qualify for federal matching funds. Specifically, C-CHIP refers to uninsured children between 250% - 300% of the federal poverty level through 18 years of age who have legal immigration status. The enclosed material will provide you with background information on the C-CHIP and guidance on the preparation of your AB495 Application Submission.

Background

Legislation

The C-CHIP Program was authorized under Assembly Bill 495, Diaz, Chapter 648, Statutes of 2001, which authorized a financial mechanism (the Children's Health Initiative Fund) in the State Treasury for purposes of providing matching funds through intergovernmental transfers to counties who provide health insurance coverage to certain children in low-income households who do not qualify for health care benefits

through the Healthy Families Program or Medi-Cal. The Fund is to accept intergovernmental transfers as the nonfederal matching funds for federal participation. Most services required under the C-CHIP mirror those provided by the Health Families Program (HFP).

AB495 was amended by AB 1130, Diaz, Chapter 687, Statutes of 2003 which authorized the Managed Risk Medical Insurance Board (MRMIB) to (1) encumber a portion of the federal matching funds to administer the C-CHIP, and (2) annually make remaining unmatched federal funds from HFP available for purposes of AB495.

State Plan Amendment (SPA)

In order to implement AB495, the California Title XXI State Plan needed to be amended. The passage of AB495 generated great interest from counties, and required a substantial amount of communications with the Federal Department of Health & Human Services Centers for Medicare & Medicaid Services (CMS) regarding requirements, policies and procedures. It was determined because of the level of interest, accommodation of requirements, and availability of local funding that the four counties of Alameda, Santa Clara, San Francisco, and San Mateo would comprise the first wave of the AB495 implementation. All four counties utilized the HFP templates for elements such as rules, processes, enrollee protections, outreach to other programs, benefits, cost sharing, etc.

In March 2003 MRMIB prepared and submitted a State Plan Amendment (SPA) which addressed the establishment of the C-CHIP. The SPA sought authorization for the four counties to establish services under the aegis of AB495. MRMIB conducted lengthy communications for many months with county, health plans, and CMS representatives regarding such items as definition of local initiatives, funding sources, and eligibility. Written documentation from CMS seeking clarification kept the clock ticking or stopped the clock of the time-limited response periods required of them. Over a period of 15 months the SPA was revised several times, with final approval being granted to MRMIB on June 10, 2004.

MRMIB and the four counties have broken “new ground” and by working together to develop the mechanism for this program to receive federal funding for children’s health coverage that was previously funded by only local funds. The experiences and learning processes of MRMIB and the initial four counties should greatly simplify the application submission process for other counties desiring to implement the C-CHIP.

New C-CHIP Implementation Efforts

Further implementation of AB495 will require that the State of California submit another State Plan Amendment to CMS. When approved, it will authorize another select group of counties to start receiving federal funds to cover federally eligible children between 250%-300% of the poverty level. The following material will provide applicants with requirements, templates, and resource information for completing a C-CHIP Application.

Application Requirements

Counties proposing to implement the C-CHIP must submit an application which contains responses to the **Required Program Information (Table 1)** and all the materials in the order listed in the **Required Application Material** section. Please ensure that the application is clearly written and addresses all the required information.

In writing your application please pay special attention to the review factors to be used by MRMIB in determining the acceptability of your application.

Program Information
It is expected that the application will fully describe the health insurance program to be offered under C-CHIP and will address all aspects of the program from administration, operations, services, costs, oversight, and reporting.

Additionally, in order to assist in the application development efforts, MRMIB has created Table 1 which highlights several important areas which need special attention because they will directly impact the development of the SPA. This important information is presented in the following table. Each inquiry/question contained in the "Required Program Information" Column is referenced to questions in the SPA template. This reference is cited so you can more fully understand why the information is needed, get acquainted with the programmatic language used in the SPA, and use the AB495 SPA as an example or guide when preparing your application. MRMIB believes that there is no need to "reinvent" text, templates, or processes.

From the CMS website you will also be able to review the lengthy and detailed questions and responses by MRMIB to gain approval of the County Expansion (C-CHIP) SPA. The SPA document contains amendments for the AIM Program as well as the C-CHIP, please note that the C-CHIP amendments appear in red ink.

TABLE 1

Required Program Information

CATEGORY	REQUIRED PROGRAM INFORMATION	SPA REFERENCE*
Coordination	• Describe how referrals of families with children potentially eligible for the Medi-Cal or HFP will occur.	Section 2.3. Coordination with other programs
Length of Eligibility	• Identify the length of eligibility proposed in the plan. Describe the proposed redeterminations process and include all documents and	Section 4.1.8. Duration of Eligibility

	instructions that will be used to conduct redeterminations.	
Eligibility Process	• Provide a description of the enrollment process to be followed by the plan.	Section 4.3. Methods of determining eligibility
Eligibility Determination	• Identify who will be responsible for determining eligibility?	Section 4.4.2. Medicaid application process
Eligibility Referencing to Plans	• Identify who will be responsible for sending enrollment information to the health, dental and vision plans?	Section 4.4.3. SCHIP enrollment
C-CHIP Sponsor	• Identify who will be the sponsor of the C-CHIP (i.e. the county, independent contractor, etc.)? What is the relationship between the sponsor and the county? If other than a county sponsor please provide information regarding decision making powers.	
Plan Licensing	• Provide an assurance that the health care service plan(s) identified in the application is/are licensed by the appropriate regulatory entity (CA Department of Managed Health Care or Department of Insurance) or copy of county organized health system approval documentation.	
Contracts	• Identify if the sponsor will contract with the health, dental, and vision plans directly or will be subcontracted through the health plans?	
Contracts	• Complete Certificate of Compliance – Standard State Compliance	Enclosure 16

Outreach	• Provide a description the outreach methods to be followed by the plan	Section 5. Outreach to families of children
Appropriateness of care	• Submit a copy of the Healthy Kids Program Application, instructions, handbook, and Evidence Of Coverage (EOC) booklet.	Section 7.1.3. Information Strategies
Correspondence Templates	• Submit a copy of all correspondence materials that will be used to correspond with the applicant (welcome letter, denial letter, request for additional information, reminder notices, appeals, disenrollments	(See selected samples in Enclosure 4)
Benefits	• Provide a description of the health, dental, and vision benefits that will be offered.	(Complete Enclosures 5, 6, and 7).
Single or Multiple Plans	• Identify who will be responsible for providing the health services, vision services, and dental services	
Plan Options	• Identify if there will be only one service plan offered in each category (health, dental. vision) or will the applicant have choice? If so, please identify the choices.	
Cost Sharing	• Identify the premium that will be charged to the applicant, any discounts for payment in advance, or any maximum limits that will be established.	Section 8.2.1. Premiums (Complete Enclosure 8)
Copayments	• Identify the copayments and the services for which participants will be charged	Section 8.2.3. Coinsurance or copayments (Also included in Enclosure 5, 6,and 7)

Funding Source(s)	• Provide a description of all the funding sources to be used. If county General Funds are used, identify the specific local revenue sources to be utilized as matching funds, including the specific fund, category and/or tax that generated the revenue.	Section 9.10. Provide projected sources of non-federal share of plan
Appeals	• Describe the Healthy Kids Program appeals process. Address how an applicant can dispute a decision made by the program and the processes in which an applicant can request continued enrollment in the program while a dispute is being reviewed, i.e. annual redetermination decision.	Section 12.1. Eligibility and Enrollment Matters
Operating Costs	• Identify total projected capitation rate and percentage of cost to be allocated for administration, including the cost to the State.	See sample invoice form (Enclosure 9)
Fiscal Reporting Requirements	• Identify how projected and actual enrollment and expenditure data will be collected and reported.	See sample Enrollment and Expenditures Budget Form (Enclosure 10)
Contact Person	• Provide the name, title, and contact information for the r\person who will be responsible for the preparation and submission of the Enrollment and Expenditure Budget reports	
County/Health Plan Relationship	• Describe the legal structure of your organization?	
County/Health Plan Relationship	• Identify whether the organization has a separate Board?	
County/Health Plan Relationship	• Describe how is the Board appointed?	
County/Health Plan Relationship	• Describe the exact relationship between the organization and: a. County government in general b. The County Board of	

	Supervisors c. The County Health Department d. The County Welfare Department	
County/Health Plan Relationship	• Identify if the organization has any formal contracts or Memoranda of Understanding with any other entity of county government for any of the organization's programs or populations served.	
County/Health Plan Relationship	• Enclose a copy of your organization's charter and/or enabling ordinance and, if applicable, your board's by-laws	
Other	• Submit any additional information or materials necessary to describe the scope of your proposed program.	

***** SPA References can be found on CMS web page as "State Clarification Submitted May11, 2004". Directions to navigate the CMS Web Page are presented in Enclosure 11.

Required Application Material

1. Clear and comprehensive description of the proposed C-CHIP program with special attention given to the responses to the questions in **Table 1**.

2. A copy of the application, instructions, and the Evidence of Coverage booklet.

3. Copies of all program correspondence to be used during the application process (i.e. welcome letter, denial letter, request for additional information, etc.), on an ongoing basis (billing statements, reminders, appeals, disenrollments, etc.), at Annual Eligibility Review (i.e. notices, forms, reminder notices, denial letters, acceptance letters, request for additional information, etc.).

4. Identification of specific local revenue sources to be utilized as matching funds. If County General Funds are to be utilized, identify tax source, etc.

5. Identification of the provider network to be utilized, i.e. the Medi-Cal, HFP, or other network.

6. Completed Benefit Matrices (Enclosures 5, 6, and 7).

7. Complete Premiums Matrix (Enclosure 8)

8. Completed Certificate of Compliance (Enclosure 16)

9. Any additional information or materials necessary to describe the scope of the proposed program.

MRMIB Review

Upon receipt of an application MRMIB will review the application in it entirety using the following factors to ensure compliance, completeness, and clarity.

1. The extent to which the program described provides comprehensive coverage including health, dental, and vision benefits.

2. Whether the application includes a promotional component to notify the public of its provision of health insurance to eligible children.

3. The simplicity of the application's procedures for applying to participate and for determining eligibility for participation in its program.

4. The extent to which the application provides for coordination and conformity with benefits provided through No Cost Medi-Cal and the Healthy Families Program, including referrals for potentially eligible children to the appropriate program.

5. The extent to which the application provides for coordination and conformity with existing Healthy Families Program administrative entities in order to prevent administrative duplication and fragmentation.

6. The ability of the health care providers designated in the application to serve the eligible population and the extent to which the application includes traditional and safety net providers, as defined in regulations adopted pursuant to the Healthy Families Program.

7. The extent to which the application intends to work with the school districts and county offices of education.

8. The total amount of funds available to implement the program described in the application, and the percentage of this amount proposed for administrative costs as well as the cost to the State to administer the application.

9. The extent to which the application seeks to minimize the substitution of private employer health insurance coverage for health benefits provided through a governmental source.

10. The extent to which local resources may be available after depletion of federal funds to continue any current program expansions for persons covered under local health care financing programs or for expanded benefits.

Application Format

Applications shall be printed using the New Times Roman type font, size 12. The pages should be double spaced and placed in 3-hole binders.

You may submit your application electronically to jlopez@mrmib.ca.gov and then sending an original hardcopy (with original signatures); or you may submit two hardcopies (at least one being an original. All the requested items must be submitted to:

Janette Lopez
Managed Risk Medical Insurance Board
P.O. Box 2769
Sacramento, CA 95812-2769

We look forward to working with you. This packet also contains several enclosures with information you may find helpful in developing your application. If you have any questions regarding this notice, contact me at (916) 324-4695.

Sincerely,

Janette Lopez
Supervising Manager
Eligibility, Enrollment and Marketing Division

ENCLOSURE 1	Contract (in development)
ENCLOSURE 2	HFP Regulations (Information Only)
ENCLOSURE 3	2004 Federal Income Guidelines
ENCLOSURE 4	Sample Applicant Correspondence (letters, notices, etc.)
ENCLOSURE 5	HFP/C-CHIP Health Benefit and Co-Payments Matrix
ENCLOSURE 6	HFP/C-CHIP Dental Benefits and Co-Payments Matrix
ENCLOSURE 7	HFP/C-CHIP Vision Benefits and Co-Payments Matrix
ENCLOSURE 8	HFP/C-CHIP Premium Matrix
ENCLOSURE 9	Sample C-CHIP Invoice Form
ENCLOSURE 10	Sample C-CHIP Enrollment and Expenditures Budget Form
ENCLOSURE 11	How to Navigate to CA SPA on CMS Web Page
ENCLOSURE 12	SPA #2 Proposed Timeline

ENCLOSURE 13 SPA Template (Information Only)
ENCLOSURE 14 Assembly Bill 495, Diaz, Chapter 648, Statutes of 2001
ENCLOSURE 15 Assembly Bill 1130, Diaz, Chapter 687, Statutes of 2003
ENCLOSURE 16 State of California Certificate of Compliance

ENCLOSURE 1

(Contract in Development)

ENCLOSURE 2

Healthy Families Program Regulations

TITLE 10: CALIFORNIA CODE OF REGULATIONS
CHAPTER 5.8 MANAGED RISK MEDICAL INSURANCE BOARD
HEALTHY FAMILIES PROGRAM

ARTICLE 1. DEFINITIONS

2699.6500. Definitions.

(a) "Access for Infants and Mothers (AIM) Program" means the State funded program operated pursuant to Part 6.3 (commencing with Section 12695) of Division 2 of the California Insurance Code, and that provides low-cost health care coverage for pregnant women and the newborns of subscribers who are enrolled in the AIM program prior to July 1, 2004.

(b) "Agriculture" means farming in all its branches and includes: the cultivation and tillage of the soil, the production of dairy products, the production, cultivation growing and harvesting of any agricultural or horticultural commodities, the raising of livestock, bees, forbearing animals, or poultry, any practice performed by a farmer or on a farm as an incident to or in conjunction with such farming operations, including preparation for market, delivery to storage or to market or to carriers for transportation to market.

(c) "AIM infant" means a child born to an AIM subscriber who is enrolled in the AIM program on or after July 1, 2004.

(d) "Alaska Native" means any person who is an Eskimo or Aleut or other Alaska Native enrolled by the Secretary of the Interior pursuant to the Alaska Native Claims Settlement Act, 43 U.S.C. 1601.

(e) "American Indian" means any person who is eligible under federal law (25 U.S.C. Section 1603) to receive health services provided directly by the United States Department of Health and Human Services, Indian Health Service, or by a tribal or an urban Indian health program funded by the Indian Health Service to provide health services to eligible individuals either directly or by contract.

(f) "Anniversary date" means the day each year that corresponds to the day and month a person's coverage began in the program.

(g) ''Applicant'' means:

(1) A person age 18 or over who is a parent; a legal guardian; or a caretaker relative, foster parent, or stepparent with whom the child resides, who applies for coverage under the program on behalf of a child.

(2) A person who is applying for coverage on his or her own behalf and who is 18 years of age; or an emancipated minor; or a minor not living in the home of a parent, a legal guardian, caretaker relative, foster parent, or stepparent.

(3) A minor who is applying for coverage on behalf of his or her child.

(4) A person who is age 19 or over and who is applying for coverage on his or her own behalf and/or that of another child-linked adult.

(h) “Benefit year” means the twelve (12) month period commencing July 1 of each year at 12:01 a.m.

(i) ‘‘Board’’ means the Managed Risk Medical Insurance Board.

(j) "Caretaker relative" means a relative who provides care and supervision to a child if there is no parent living in the home. The caretaker relative may be any relation by blood, marriage, or adoption.

(k) "Child-linked adult" means:

(1) A parent living in the home with his or her child under age 19 who is enrolled in the program, or in no-cost Medi-Cal, or is eligible and applying for no-cost Medi-Cal.

(2) A stepparent living in the home with the parent described in (1).

(3) A caretaker relative living in the home with a child under age 19 who is enrolled in the program, or in no-cost Medi-Cal, or is eligible and applying for no-cost Medi-Cal. For any child or group of siblings, only one (1) caretaker relative may be eligible as a child-linked adult.

(4) A legal guardian living in the home with a child under age 19 who is enrolled in the program, or in no-cost Medi-Cal, or is eligible and applying for no-cost Medi-Cal. For any child or group of siblings, only one (1) legal guardian may be eligible as a child-linked adult.

(l) “Community provider plan” means that participating health plan in each county that has been so designated by the Board pursuant to Section 2699.6805.

(m) “Family contributions’’ means the monthly cost to an applicant for “family child contributions” and “family parent contributions.” Family contributions do not include copayments for services.

(n) “Family child contributions” means the monthly cost to an applicant to enable a subscriber child or subscriber children to participate in the program. Family child contributions do not include copayments for services.

(o) “Family parent contributions” means the monthly cost to an applicant to enable a subscriber parent or subscriber parents to participate in the program. Family parent contributions do not include copayments for services.

(p) “Family contribution sponsor” means a person or entity that is registered with the Program and that pays the family child contributions and/or family parent contributions on behalf of an applicant for any twelve (12) consecutive months of the subscriber child or subscriber parent’s participation in the program. A family contribution sponsor may sponsor a subscriber parent linked to a subscriber child enrolled in the program if the subscriber child is sponsored, or may sponsor only the subscriber parent if the subscriber parent is not linked to any subscriber children enrolled in the program and instead is linked to a child enrolled in no-cost Medi-Cal.

(q) "Family member" means the following persons living in the home, unless the individual receives public assistance benefits such as SSI/SSP:

(1) Children under age 21 of married or unmarried parents living in the home.

(2) The married or unmarried parents of the child or sibling children.

(3) The stepparents of the child or sibling children.

(4) An unborn child of any family member.

(5) Children under age 21 who are away at school and who are claimed as tax dependents.

(r) “Family value package” means the combination of participating health, dental, and vision plans available to subscribers in each county offering the lowest price and each of the combinations offering a price within seven and one half percent (7.5%) of the average price of the lowest priced combination and the second lowest price combination of health, dental, and vision plans. The second lowest price combination is calculated by summing the second lowest price health plan, the second

lowest price dental plan, and the second lowest price vision plan. If only one health, dental, or vision plan is available to subscribers in a county, the price of the one available plan shall be used in the calculations of the second lowest price combination. A health, dental, or vision plan with a service area which does not include zip codes in which at least eighty-five percent (85%) of the residents of the county reside or that has enrollment limits unrelated to network capacity shall not be considered the lowest or second lowest price plan, unless it is the only health, dental, or vision plan in the county. In addition, any combination of health, dental, and vision plans in which the health, dental, and vision plan are each available in at least one plan combination that is within seven and one half percent (7.5%) of the average price of the lowest and second lowest price combination of health, dental, and vision plans, is a family value package. In all family value package calculations, the health plan rate to be used is the rate for subscriber children from one year old up to the age of nineteen. The dental and vision plan rates to be used are the rates for subscriber children. The family value package determinations shall be made once each year by the Board, no later than the last day of March for the following benefit year, based on calculations using the prices of the plans that at the time of the calculations are expected to be available the following benefit year. Calculations will not be redone if plans are later dropped from or added to a county. However, if the Board at any time determines that the seven and one half percent (7.5%) level is insufficient to assure that adequate network capacity exists in a specified county so that all subscribers may be enrolled in a family value package, the Board may increase the percentage for that county to a percentage at which sufficient capacity is assured. Such increased percentage shall be in effect only for the benefit year in which the increase is made. The Board may determine, if requested as a part of a rural demonstration project for a special population, that a combination of health, dental, and vision plans in a county with a price higher than the family value package may still be deemed a family value package for applicants and subscribers that are members of the special population; in addition the Board may determine, if requested as part of a rural demonstration project for rural area residents, that a combination of health, dental, and vision plans in a county with a price higher than the family value package may still be deemed a family value package for subscribers that are residents of the rural area. The Board may determine that a combination of health, dental, and vision plans in a county that includes health and vision plans available in at least one family value package plan combination is deemed a family value package even if the dental plan is not in any other family value package plan combination, but only for applicants with subscribers who are enrolled prior to the beginning of the benefit year in that dental plan, and only if the Board determines it necessary in order to avoid requiring fifty percent (50%) of subscribers or one-thousand (1,000) subscribers in a county to change their dental plan.

(s) “Federal Poverty Level” means the level determined by the “Poverty Guidelines for the 48 Contiguous States and the District of Columbia” as contained in the Annual Update of HHS Poverty Guidelines as published in the Federal Register by the U.S. Department of Health and Human Services.

(t) "Household income" means the total annual income of all family members in a household. Income includes before tax earnings from a job, including cash, wages, salary, commissions and tips, self employment net profits, Social Security, State Disability Insurance (SDI), Retirement Survivor Disability Insurance (RSDI), veterans benefits, Railroad Retirement, disability workers’ compensation, unemployment benefits, child support, alimony, spousal support, pensions and retirement benefits, loans to meet personal needs, grants that cover living expenses, settlement benefits, rental income, gifts, lottery/bingo winnings and interest income. Income excludes public assistance program benefits such as SSI/SSP and CalWORKS payments, foster care payments, general relief, loans, grants or scholarships applied toward college expenses, or earned income of a child aged 13 or under, or a child attending school. Income does not include income exclusions applicable to all federal means tested programs such as, disaster relief payments, per capita payments to Native Americans from proceeds held in trust and/or arising from use of restricted lands, Agent Orange payments, Title IV student assistance, energy assistance payments to low income families, relocation assistance payments, victims of crime assistance program, Spina Bifida payments, earned income tax credit and Japanese reparation payments.

(u) “Income deduction” means any of the following:

(1) Work expenses of $90 per month for each family member working or receiving disability worker’s compensation or State Disability Insurance. If a family member earns less than $90, the deduction can only be for the amount earned.

(2) Child care expenses while a family member works or trains for a job of up to $200 per month for each family member under age 2, up to $175 per month for each family member over age 2 and dependent care expenses of up to $175 for a disabled dependent.

(3) The amount paid by a family member per month for any court ordered alimony or child support.

(4) A maximum of $50 for child support payments or alimony received. If less than $50 in child support and/or alimony is received, the deduction can only be for the amount received.

(v) "Indian Health Service Facility" means a tribal or urban Indian organization operating health care programs or facilities with funds from the United States Department of Health and Human Service's Indian Health Service, pursuant to the Indian Health Care Improvement Act (25 U.S.C. Section 1601) or the Snyder Act (25 U.S.C. Section 13).

(w) "Living in the home" means all of the following:

(1) Physically present in the home;

(2) Temporarily absent from the home because of hospitalization, visiting, vacation, work-related trips, or other similar reasons. A temporary absence is normally one where a person leaves and returns to the home in the same or the following month.

(3) Away at school or vocational training if the person will resume living in the home as evidenced by the person's return to the home for vacations, weekends, and other times.

(4) When a child stays alternately with each of his or her parents and the child's parents are separated or divorced, the home in which the child is living shall be determined as follows:

(A) The child is determined to be living in the home of the parent with whom the child stays for the majority of the time.

(B) If the child spends an equal amount of time with each parent, the child is determined to be living in the home of the parent who has the majority of the responsibility for the care of the child. Factors that determine majority responsibility include but are not limited to which parent decides where the child attends school, deals with the school on educational decisions and problems, controls participation in extracurricular and recreational activities, arranges medical and dental care services, claims the child as a tax dependent, and purchases and maintains the child's clothing.

(C) If both parents exercise an equal share of responsibility for the child and the child spends an equal amount of time with each parent, the child is determined to be living in the home of the parent who meets one of the following conditions in the order specified:

1. Is designated, through mutual agreement of both parents, as the primary parent for purposes of the program or Medi-Cal.

2. Is otherwise eligible for the program.
3. If both parents are eligible for the program then the child is determined to be living in the home of the parent who first applied for the program or Medi-Cal on behalf of the child.

(x) "Migratory worker" means an individual whose principal employment is in agriculture, fishing, and/or forestry, on a seasonal basis, as opposed to year-round employment; and who, for purposes of employment, does establish a temporary place of residence. Migrant workers live in a work area temporarily. Such employment must have been within the last twenty-four months.

(y) "Parent" means the natural or adoptive parent of a child.

(z) "Parental coverage start date" means the effective date for which the State of California enacts appropriation for the coverage of child linked adults pursuant to a budget act and/or any other applicable state statute.

(aa) ''Participating dental plan'' means any of the following plans that is lawfully engaged in providing, arranging, paying for, or reimbursing the cost of personal dental services under insurance policies or contracts, or membership contracts, in consideration of premiums or other periodic charges payable to it, and that contracts with the Board to provide coverage to program subscribers:

(1) A dental insurer holding a valid outstanding certificate of authority from the Insurance Commissioner.

(2) A specialized health care service plan as defined under subdivision (o) of Section 1345 of the Health and Safety Code.

(bb) ''Participating health plan'' means any of the following plans that is lawfully engaged in providing, arranging, paying for, or reimbursing the cost of personal health care services under insurance policies or contracts, medical and hospital service arrangements, or membership contracts, in consideration of premiums or other periodic charges payable to it, and that contracts with the Board to provide coverage to program subscribers:

(1) A private health insurer holding a valid outstanding certificate of authority from the Insurance Commissioner.

(2) A health care service plan as defined under subdivision (f) of Section 1345 of the Health and Safety Code. The term health care service plan shall include a plan operating as a geographic managed care plan as defined in Insurance Code Section 12693.16, in the area which it operates pursuant to a contract entered into under Article 2.91 (commencing with Section 14089 of Chapter 7 of Part 3 of Division 9 of the Welfare and Institutions Code.

(3) A county organized health system as defined in Insurance Code Section 12693.05, in the county in which it provides comprehensive health care to eligible Medi-Cal beneficiaries.

(4) A local initiative as defined in Insurance Code Section 12693.08, in the region in which it provides comprehensive health care to eligible Medi-Cal beneficiaries.

(cc) "Participating plan" means a participating health, participating dental or participating vision care plan.

(dd) ''Participating vision care plan'' means any of the following plans that is lawfully engaged in providing, arranging, paying for, or reimbursing the cost of personal vision services under insurance policies or contracts, or membership contracts, in consideration of premiums or other periodic charges payable to it, and that contract with the Board to provide coverage to program subscribers:

(1) A vision insurer holding a valid outstanding certificate of authority from the Insurance Commissioner.

(2) A specialized health care service plan as defined under subdivision (o) of Section 1345 of the Health and Safety Code.

(ee) ''Program'' means the Healthy Families Program.

(ff) (1) "Qualified alien" means an alien who, at the time he or she applies for, receives, or attempts to receive program benefits, is, under Section 431 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA) (8 U.S.C. Section 1641), any of the following:

(A) An alien lawfully admitted for permanent residence under the Immigration and Naturalization Act (INA) (8 U.S.C. Section 1101 et seq.).

(B) An alien who is granted asylum under Section 208 of the INA (8 U.S.C. Section 1158).

(C) A refugee who is admitted to the United States under Section 207 of the INA (8 U.S.C. Section 1157).

(D) An alien who is paroled into the United States under Section 212(d)(5) of the INA (8 U.S.C. Section 1182 (d)(5)) for a period of at least one year.

(E) An alien whose deportation is being withheld under Section 243(h) of the INA (8 U.S.C. Section 1253(h), as in effect immediately before the effective date (April 1, 1997) of Section 307 of Division C of Public Law 104-208, or Section 241(b)(3) of such Act (8 U.S.C. Section 1251(b)(3)) (as amended by Section 305(a) of Division C of Public Law 104-208).

(F) An alien who is granted conditional entry pursuant to Section 203(a)(7) of the INA as in effect prior to April 1, 1980 (8 U.S.C. Section 1153(a)(7)). (See editorial note under 8 U.S.C. Section 1101, "Effective Date of 1980 Amendment.")

(G) An alien who is a Cuban and Haitian entrant (as defined in Section 501(e) of the Refugee Education Assistance Act of 1980) (8 U.S.C. Section 1522nt.).

(H) An alien who, under Section 431(c)(1) of PRWORA (8 U.S.C. Section 1641 (c)(1)), meets all of the conditions of subparagraphs 1., 2., 3., and 4. below:

1. The alien has been battered or subjected to extreme cruelty in the United States by a spouse or a parent, or by a member of the spouse's or parent's family residing in the same household as the alien, and the spouse or parent of the alien consented to, or acquiesced in, such battery or cruelty.

2. There is a substantial connection between such battery or cruelty and the need for the benefits to be provided.

3. The alien has been approved or has a petition pending which sets forth a prima facie case for any of the following:

a. Status as a spouse or child of a United States citizen pursuant to clause (ii), (iii), or (iv) of Section 204(a)(1)(A) of the INA (8 U.S.C. Section 1154(a)(1)(A)(ii), (iii) or (iv)).

b. Classification pursuant to clause (ii) or (iii) of Section 204(a)(1)(B) of the INA (8 U.S.C. Section 1154 (a)(1)(B)(ii) or (iii)).

c. Cancellation of removal under Section 240A of the INA (8 U.S.C. Section 1229b) (as in effect prior to April 1, 1997).

d. Status as a spouse or child of a United States citizen pursuant to clause (i) of Section 204(a)(1)(A) of the INA (8 U.S.C. Section 1154(a)(1)(A)(i)) or classification pursuant to clause (i) of Section 204(a)(1)(B) of the INA (8 U.S.C. Section 1154(a)(1)(B)(i)).

e. Cancellation of removal pursuant to Section 240A(b)(2) of the INA (8 U.S.C. Section 1229b(b)(2)).

4. For the period for which benefits are sought, the individual responsible for the battery or cruelty does not reside in the same household or family eligibility unit as the individual subjected to the battery or cruelty.

(I) An alien who, under Section 431(c)(2) of the PRWORA (8 U.S.C. Section 1641 (c)(2)), meets all of the conditions of subparagraphs 1., 2., 3., 4. and 5. below:

1. The alien has a child who has been battered or subjected to extreme cruelty in the United States by a spouse or a parent of the alien (without the active participation of the alien in the battery or cruelty), or by a member of the spouse's or parent's family residing in the same household as the alien, and the spouse or parent consented or acquiesced to such battery or cruelty.

2. The alien did not actively participate in such battery or cruelty.

3. There is a substantial connection between such battery or cruelty and the need for the benefits to be provided.

4. The alien meets the requirements of subparagraph (H)(3) above.

5. For the period for which benefits are sought, the individual responsible for the battery or cruelty does not reside in the same household or family eligibility unit as the individual subjected to the battery or cruelty.

(J) An alien child who meets all of the conditions of subparagraphs 1., 2., 3., and 4. below:

1. The alien child resides in the same household as a parent who has been battered or subjected to extreme cruelty in the United States by that parent's spouse or by a member of the spouse's family residing in the same household as the parent and the spouse consented or acquiesced to such battery or cruelty.

2. There is a substantial connection between such battery or cruelty and the need for the benefits to be provided.

3. The alien child meets the requirements of subparagraph (H)(3) above.

4. For the period for which benefits are sought, the individual responsible for the battery or cruelty does not reside in the same household or family eligibility unit as the individual subjected to the battery or cruelty.

(2) For purposes of subparagraphs (1)(H), (1)(I), and (1)(J), there is a "substantial connection between such battery or cruelty and the need for benefits to be provided" if the alien declares, and the program verifies, any of the following circumstances:

(A) The alien or the alien's child is receiving cash assistance based on the battery or extreme cruelty.

(B) The benefits are needed due to a loss of financial support resulting from the alien's and/or his or her child's separation from the abuser.

(C) The benefits are needed because the alien or his or her child requires medical attention or mental health counseling, or has become disabled, as a result of the battery or cruelty.

(D) The benefits are needed to provide medical care during a pregnancy resulting from the abuser's sexual assault or abuse of, or relationship with, the alien or his or her child, and/or to care for any resulting children.

(E) The medical coverage and/or health care services are needed to replace medical coverage or health care services the applicant or child had when living with the abuser.

(3) An alien who is a qualified alien pursuant to subparagraphs (1)(H), (1)(I), or (1)(J), will remain eligible for the program as long as the need for benefits related to the battery or cruelty is necessary as determined by the program, and the alien continues to meet all other program eligibility requirements. The program shall review the alien's circumstances to evaluate the subscriber's continued need for program benefits at the annual eligibility review.

(gg) "Qualifying event" means one of the following situations in which a child-linked adult may enroll in the program:

(1) A subscriber child through whom the child-linked adult is eligible enrolls in no-cost Medi-Cal or the program and the child-linked adult requests enrollment at the same time as the child. If the child-linked adult is not the applicant on behalf of the subscriber child, the child-linked adult may request enrollment within 2 months of the subscriber child's enrollment in no-cost Medi-Cal or the program.

(2) A subscriber child through whom the child-linked adult is eligible qualifies for an additional year of coverage under no-cost Medi-Cal or the program pursuant to Section 2699.6625 and the child-linked adult requests enrollment at the time of the child's annual eligibility review. If the child-linked adult is not the applicant on behalf of the subscriber child, the child-linked adult may request enrollment within 2 months of the subscriber child's qualification for an additional year of coverage through no-cost Medi-Cal or the program.

(3) A child-linked adult loses no-cost Medi-Cal coverage and requests enrollment within 2 months after notification of this loss of coverage.

(4) A subscriber child turns 19 and qualifies to participate in the program as a subscriber parent, and requests enrollment within 2 months of his or her 19th birthday.

(5) A child-linked adult has lost or will lose coverage under employer sponsored coverage as a result of one of the following and the child-linked adult requests enrollment within 2 months of the termination of coverage.

(A) The child-linked adult or other individual through whom the child-linked adult was covered lost employment or experienced a change in employment status.

(B) The child-linked adult or other individual through whom the child-linked adult was covered changed address to a zip code that is not covered by the employer-sponsored coverage.

(C) The employer of the child-linked adult or other individual through whom the child-linked adult was covered discontinued health benefits to all employees or dependents, or ceased to provide coverage or contributions for one or more categories of employees or dependents.

(D) Death of the individual, through whom the child-linked adult was covered, or a legal separation or divorce from the individual through whom the child-linked adult was covered.

(E) The child-linked adult was covered under a COBRA policy, and the COBRA coverage period has ended.

(6) A subscriber parent's period of disqualification pursuant to Subsection 2699.6611(d) has expired and enrollment is requested within 2 months of the end of the period of disqualification.

(7) The household income for a child-linked adult falls to a level at or below 200% of the federal poverty level and the child-linked adult requests enrollment within 2 months of this change in income.

(8) A subscriber parent marries and his or her spouse requests

enrollment within 2 months of newly obtaining the status of a child-linked adult.

(9) A subscriber child begins living in the home with a parent, caretaker relative, or legal guardian and the parent, caretaker relative, or legal guardian requests enrollment within 2 months of newly obtaining the status of a child-linked adult.

(10) The program informs a child-linked adult who previously applied at a time when the program was closed to new enrollment that he or she may apply and he or she requests enrollment within 2 months of notification of the program's opening to new enrollment for child-linked adults.

(hh) “Rural demonstration projects” means health, dental and vision plan projects approved by the Board to address the unique access needs of special populations and/or residents of rural medical service study areas.

(ii) “Rural Medical Service Study Area” means an area with (1) a population density of less than 250 persons per square mile: and (2) no town with a population in excess of 50,000 within the area, as determined by the Office of Statewide Health Planning and Development.

(jj) “Seasonal worker” means an individual whose principal employment is in agriculture, fishing and/or forestry, on a seasonal basis, as opposed to year-round employment; and who, for purposes of employment, does not establish a temporary place of residence. Seasonal workers commute to work in the area of their permanent address. Such employment must have been within the last twenty-four months.

(kk) “Special population” means seasonal workers, migratory workers or American Indians.

(ll) “State Supported Services” means abortions that are not the result of incest or rape, and are not necessary to save the life of the mother.

(mm) "Stepparent" means a person who is married to the parent of a child and who is not the other parent of the child.

(nn) "Subscriber" means either a “subscriber child” or a “subscriber parent.”

(oo) “Subscriber child” means a person age 18 or a child who is eligible for and participates in the program.

(pp) “Subscriber parent” means a child-linked adult age 19 or over who is eligible for and participates in the program.

(qq) Tenses, and Number. The present tense includes the past and future, and the future the present; the singular includes the plural and the plural the singular.

NOTE: Authority cited: Sections 12693.21 and 12693.755, Insurance Code. Reference: Sections 12693.02, 12693.03, 12693.045, 12693.06, 12693.065, 12693.08, 12693.09, 12693.10, 12693.70, 12693.105, 12693.11, 12693.12, 12693.13, 12693.14, 12693.16, 12693.17, 12693.755 and 12693.91, Insurance Code.

ARTICLE 2. ELIGIBILITY, APPLICATION, AND ENROLLMENT

2699.6600. Application.

(a) To apply for the program:

(1) An applicant shall submit all information, documentation, and declarations required in subsection (c) of this section and a personal check, cashier's check or money order for the first month's required family contribution for the program, or a personal check, cashier's check or money order for the first three months' required family contribution if the applicant wishes to receive the fourth month of coverage with no required family contribution.

(2) No payment from the applicant pursuant to (1) is required if the applicant has a family contribution sponsor and both the sponsor's family contribution payment for twelve (12) months and the family contribution sponsorship payment form accompany the application.

(3) No payment from the applicant pursuant to (1) is required if the applicant or the person for whom application is being made is American Indian or Alaska Native and submits acceptable documentation as described in Subsection (c)(1)(FF).

(4) Payment in full of the following arrears, incurred within the prior twelve (12) months, by the applicant is required prior to enrollment of a person under age 19:

(A) Family child contributions owed on behalf of any person under age 19 for whom the same applicant previously applied;

(B) Family child contributions owed on behalf of a person under age 19 for whom the applicant did not previously apply but for whom the applicant is currently requesting coverage if the applicant:

1. Is the parent of the person under age 19 for whom premiums are owed; and

2. Lived in the same home as the person under age 19 when the premiums were incurred.

(5) Payment in full of the following arrears, incurred within the prior

twelve (12) months, by the applicant is required prior to enrollment of a person age 19 or over:

(A) Family contributions owed on behalf of any person for whom the same applicant previously applied;

(B) Family child contributions owed on behalf of a person under age 19 for whom the applicant did not previously apply but for whom the applicant is currently requesting coverage if the applicant:

1. Is the parent of the person under age 19 for whom premiums are owed; and

2. Lived in the same home as the person under age 19 when the premiums were incurred.

(C) Family parent contributions owed on behalf of a person for whom the applicant is requesting coverage for coverage provided on or after the person's 19th birthday.

(6) The program application, entitled "Family Health Coverage Mail-In Application, for Medi-Cal and Healthy Families" (MC321 HFP, June, 2002 New), is hereby incorporated by reference.

(b) The applicant shall sign and date the following declaration: I declare under penalty of perjury under the laws of the State of California that the answers I have given in this Application and the documents given are correct and true to the best of my knowledge and belief. I declare that I have read and understand the Application Instructions, the declarations, and all information printed on this Application.

(c) (1) The application shall contain the following:

(A) The applicant's full name.

(B) The applicant's date of birth.

(C) The applicant's primary written and oral language.

(D) The home and mailing address for the applicant and for all persons for whom application is being made, the applicant's county of residence and phone number(s), and the applicant's e-mail address (optional).

(E) An indication of whether the applicant is over the age of 18 years and applying on behalf of a child or children, and/or

on behalf of a child-linked adult. An indication of whether the applicant is an 18 year old applying on his or her own behalf; the applicant is an emancipated minor applying on his or her own behalf; the applicant is a minor who is not living in the home of a parent, legal guardian, caretaker relative, foster parent, or stepparent and is applying on his or her own behalf; or the applicant is a minor who is applying on behalf of his or her child.

(F) For each person for whom the applicant is applying, the following information is requested:

1. name (first, middle and last) including full birth name if different (not required for a child not yet born)

2. marital status and spouse's name

3. birth date (not required for a child not yet born)

4. birth place (not required for a child not yet born)

5. mother's first and last name and whether living in the child's household (optional for a person age 19 or over)

6. father's first and last name if living in the child's household (optional for a person age 19 or over)

7. an indication of whether the mother and father are deceased or disabled (optional for a person age 19 or over)

8. gender (not required for a child not yet born)

9. Social Security Number (optional)

10. ethnicity (optional unless the person is an American Indian),

11. relationship to applicant.

12. if the person lives away from home (optional for a person age 19 or over)

13. if the person is going to school

14. if the person has a physical, mental or emotional disability
15. if any person in the home is pregnant and if so, the expected due date

(G) A declaration that the applicant is applying to enroll in the program all of the applicant's eligible children who are not already enrolled in the program, unless the applicant is applying only on his or her own behalf.

(H) An identification of individuals living together in the home and their relationships. If an individual is pregnant, it should be indicated, along with the expected due date.

(I) A list of family members identified in (F) and (H) above, who live in the home and who had income in the previous or current calendar year.

1. If the applicant is a parent or stepparent, an 18 year old applying on their own behalf, a child-linked adult applying on his or her own behalf or that of another child-linked adult or a minor applying on his or her own behalf or on behalf of his or her child, for the household of each person applied for, the first, middle initial, last name, gender and date of birth of all family members living in the household, each person's relationship to the person applied for and their monthly income.

2. If the applicant is applying as a foster parent, caretaker relative, or legal guardian applying only on behalf of an 18 year old or a child, a statement of the monthly income of each person applied for whom they are a foster parent, caretaker relative, or legal guardian.

3. If the person for whom application is being made is a qualified alien with an affidavit of support pursuant to section 213A of the Immigration and Naturalization Act, the calculation of household income must include the sponsor's income as set forth in Section 421 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA), unless the person is eligible pursuant to Insurance Code Section 12693.76.

(J) Beginning one year after the parental coverage start date, for each child-linked adult for whom application is being made, an indication of his or her qualifying event as defined in Section 2699.6500.

(K) Documentation of the total monthly gross household income for either the previous or current calendar year. For each person listed pursuant to subsections (F) and (H) above, provide social security number (optional) and documentation for each source of income. Such documentation shall be provided for the previous or current year as indicated below:

1. For the previous calendar year:

   a. Federal tax return. If self-employed, a schedule C must be included. If a person with reported income on the federal tax return is a step-parent, the step-parent's W-2 form is required to determine the amount of income associated with the financially responsible parent of the child being applied for.

   b. All of the following that are applicable and that reflect the current benefit amount: copies of award letters, checks, ~~or~~ bank statements, passbooks, or internal revenue service (IRS) 1099 forms showing the amount of Social Security, State Disability Insurance (SDI), Retirement Survivor Disability Insurance (RSDI), veterans benefits, Railroad Retirement, disability workers' compensation, unemployment benefits, child support, alimony spousal support, pensions and retirement benefits, loans to meet personal needs, grants that cover living expenses, settlement benefits, rental income, gifts, lottery/bingo winnings, dividends, or interest income.

2. For the current calendar year:

   a. Paystub or unemployment stub showing gross income for a period ending within 45

days of the date the program receives the document.

b. A letter from the person's current employer. The letter shall be dated and written on the employer's letterhead, and shall include the following:

i. The employee's name.

ii. The employer's business name, business address, and phone number.

iii. A statement of the person's current gross monthly income for a period ending within 45 days of the date the program receives the document.

iv. A statement that the information presented is true and correct to the best of the signer's knowledge.

v. A signature by someone authorized to sign such letters by the employer. The signer shall include his or her position name or job title and shall not be the person whose income is being disclosed.

c. If self employed, a profit and loss statement for the most recent three (3) month period prior to the date the program receives the document. A profit and loss statement must include the following:

i. Date.

ii. Name, address, and telephone number of the business.

iii. Gross income, gross expenses, and net profit itemized on a monthly basis.

iv. A statement on the profit and loss, signed by the person who earned the income, which states, "the information provided is true and

correct."

d. A letter or Notice of Action from the County Welfare Office issued within the last two (2) months that includes:

i. For each person for whom application is being made, a statement that the person is eligible for share-of-cost Medi-Cal,

ii. A determination of total monthly household income and monthly household income after income deductions as defined in Section 2699.6500, and

iii. A determination of the number of family members living in the household.

e. All of the following that are applicable and that reflect the current benefit amount: copies of award letters, checks, bank statements, or passbooks showing the amount of Social Security, State Disability Insurance (SDI), Retirement Survivor Disability Insurance (RSDI), veterans benefits, Railroad Retirement, disability workers' compensation, unemployment benefits, child support, alimony, spousal support, pensions and retirement benefits, loans to meet personal needs, grants that cover living expenses, settlement benefits, rental income, gifts, lottery/bingo winnings, dividends, or interest income for the previous month.

3. If documentation pursuant to 1. or 2. cannot be provided, an affidavit of income written by hand by the recipient of the income. If the individual who receives the income is unable to write the affidavit by hand because of physical or literacy limitations, the individual will sign an affidavit written on his or her behalf with a mark (unless physically incapable) and include the printed name and signature of a witness. The affidavit of income shall include the following:

a. A statement of the amount and frequency of the income received,

b. A declaration that the individual cannot provide other documentation of his or her income at the time of application to the program and that the information provided is true and correct to the best of the individual's knowledge and belief,

c. An acknowledgment that the individual understands that the information contained in his or her affidavit may be subject to a verification by the State, and

d. The signature of the individual providing the affidavit of income and the date of signature.

(L) The name of each family member living in the home who pays court ordered child support, court ordered alimony, or health insurance and the monthly amount paid. The name and age of each person for whom payments are made for child care and/or disabled dependent care by a family member living in the home and the monthly amount paid. Documentation of court ordered child support and/or alimony paid, health insurance paid, and child care and/or disabled dependent care expenses paid. Documentation includes copies of court orders, cancelled checks, receipts, statements from the District Attorney's Family Support Division or other equivalent document.

(M) A declaration that each person for whom application is being made is not eligible for Part A and Part B of Medicare.

(N) A declaration that each person for whom application is being made is a resident of the State of California pursuant to Section 244 of the Government Code; or is physically present in California and entered the state with a job commitment or to seek employment.

(O) A declaration that the applicant will notify the program within 30 days of any change of home or mailing address of any person applied for who is accepted into the program and any change in the applicant's home or mailing address.

(P) A declaration that the applicant and each person for whom application is being made will abide by the rules of

participation of the program.

(Q) A declaration that the applicant and each person for whom application is being made will abide by the rules and adhere to the policies and procedures, including dispute resolution processes, of any participating plan in which such persons are enrolled.

(R) For each person for whom application is being made, indicate current employer sponsored health coverage or employer sponsored health coverage that was terminated in the last three months, including the reason for and date of the termination.

(S) For each person for whom application is being made, the applicant's declaration that the person is:

1. a citizen or national of the United States, or

2. a qualified alien who entered the United States prior to August 22, 1996 or who entered on or after August 22, 1996 and meets one of the criteria listed in Subsection 2699.6607 (e)(2)(B), or

3. a qualified alien who does not meet the criteria specified in subsection (R)2. above.

(T) For each declaration made pursuant to (~~R~~S), documentation of the individual's status. If documentation is unavailable at the time of application, persons declaring a status listed under subsection (S) above may submit documentation within two months from the date of enrollment. If any person for whom application is being made was previously disenrolled pursuant to Section 2699.6611(a)(3), documentation for that person shall be submitted with the application.

(U) A declaration that each person for whom application is being made is not eligible for any California Public Employees Retirement System Health Benefits Program(s) or is eligible for a California Public Employees Retirement Health Benefits Program but the employer contribution for dependent(s) is less than $10.

(V) A declaration that each person for whom application is being made is not an inmate in a public correctional

institution, or a patient in an institution for mental illness.

(W) A declaration that the applicant gives permission for the program to verify family income, health coverage, immigration status of each person for whom application is being made, California residence and other facts stated in the application.

(X) For each person for whom application is being made, an indication of whether the person has other health, dental or vision insurance.

(Y) An indication of whether anyone has filed a lawsuit because of an accident or injury on behalf of any person for whom application is being made.

(Z) An indication of whether the applicant wants to apply for Medi-Cal coverage for any unpaid medical expenses in the last three months prior to application for any person for whom application is being made.

(AA) The applicant shall provide all of the following:

1. A declaration that the applicant has reviewed the benefits offered by the participating health, dental and vision plans.

2. The applicant's choice of participating health, dental, and vision plans.

3. A declaration that the applicant agrees to pay the required family contribution for a period of six months, unless the applicant has a family contribution sponsor.

(BB) The applicant may provide the following optional information:

1. The applicant's choice of primary care provider/clinic and provider/clinic code, and dentist/clinic and dentist/clinic code for the person(s) for whom application is being made.

2. An indication of whether there is more than one car in the children's household.

3. An indication of whether there is more than $3,150 cash in bank accounts in the children's household.

4. An indication if the applicant does not want the application reviewed for eligibility for Medi-Cal or the Program.

(CC) If assistance in completing the application was provided by an eligible individual, a statement by the applicant that such assistance was provided.

(DD) If applicable, a declaration that the applicant is a migratory worker or seasonal worker as defined in Section 2699.6500.

(EE) If applicable, the applicant's signed authorization that the program may release information over the telephone about the application status of the individual(s) applied for by the applicant to a representative of the enrollment entity designated by the applicant on the application. This permission will end on the date the program mails the results of the eligibility determination on this application.

(FF) If the applicant received assistance from a certified application assistant, the applicant's signed authorization (if applicable) that the program may release information notifying the entity with whom the certified application assistant is affiliated of the applicant's Annual Eligibility Review date.

(GG) If an applicant or the person for whom application is being made is American Indian or Alaska Native, acceptable documentation must be submitted to exempt the applicant from family contribution payments and benefit copayments. The exemption from family contributions and benefit copayments shall occur after receipt of such documentation. Notwithstanding the previous sentence, the exemption from family contributions will begin on the date of enrollment and continue for two months pending the receipt of acceptable documentation. If acceptable documentation is not received at the end of the two month exemption period, the appropriate family contribution will be assessed pursuant to Subsection 2699.6813(a). The applicant must indicate on the application that he or she is requesting a waiver of the family contributions.

Acceptable documentation for the applicant or the child includes:

1. An American Indian or Alaska Native enrollment document from a federally recognized tribe, or

2. A Certificate Degree of Indian Blood (CDIB) from the Bureau of Indian Affairs, or

3. A letter of Indian heritage from an Indian Health Service supported facility operating in the State of California.

(HH) An indication of how the applicant learned about Medi-Cal and the program.

(II) An indication whether the applicant would like information sent to them regarding the Child Health and Disability Prevention Program (CHDP) for children and youth or the Women, Infants and Children (WIC) program.

(2) The Social Security numbers and other personal information are needed for identification and administrative purposes.

NOTE: Authority cited: Sections 12693.21 and 12693.755, Insurance Code. Reference: Sections 12693.02, 12693.21, 12693.43, 12693.46, 12693.70, 12693.71, 12693.73, 12693.74, 12693.75 and 12693.755, Insurance Code.

2699.6603. Early Applications.

An applicant may apply to the program in advance for persons who are not eligible at the time of application, but who the applicant believes will become eligible within three (3) months because of one of the following:

(a) They are currently enrolled in the Medi-Cal 200% Program and will become one year old.

(b) They are currently enrolled in the Medi-Cal 133% Program and will become age 6.

(c) They are currently on Medi-Cal for at least one month of continued eligibility under no cost, full scope Medi-Cal and have been notified by the county welfare office that coverage is ending.

(d) It is anticipated that the child will be born. When the child is born, an applicant must submit documentation of the child's birth to the program, and must include the child's name, place and date of birth, and gender. The documentation and information must be received by the program within thirty (30) days from the birth for a child to be eligible pursuant to this section. Acceptable forms of documentation include a certificate of birth provided by a hospital or other health care facility, a signed statement by the health practitioner who presided over the delivery, or an equivalent document.

NOTE: Authority cited: Section 12693.21, Insurance Code.
Reference: Sections 12693.21, 12693.70, Insurance Code.

2699.6605. Initial Review of Application.

(a) Upon receipt of an application or an Add a Person Application form, the program shall determine if there is funding available for additional enrollment of child-linked adults in the program.

(b) (1) If there is no funding available for coverage of child-linked adults and the Board estimates that the program will be closed to new enrollment of child-linked adults for less than six (6) consecutive weeks, applications will be reviewed for completeness as set forth in Section 2699.6606 below and if complete, for eligibility. For persons age 19 and over who are determined to be eligible, the program will retain the applicant's family parent contributions payment to use to enroll the eligible child-linked adult(s) in the program once a vacancy opens in the program. The applicant may request a refund of the family parent contributions payment but the child-linked adult for whom enrollment was requested will be removed from the program waiting list. Persons age 19 and over for whom application is being made who are determined to be eligible will be placed on a waiting list in the following categories:

(A) Child-linked adults with an annual household income after income deductions of up to and including 100 percent of the federal poverty level.

(B) Child-linked adults with an annual household income after income deductions greater than 100 percent and up to and including 150 percent of the federal poverty level.

(C) Child-linked adults with an annual household income after income deductions greater than 150 percent and up to and including 200 percent of the federal poverty level.

(2) The waiting list will be maintained as follows:

(A) Child-linked adults in category (b)(1)(B) will be placed ahead of child-linked adults in category (b)(1)(C) on the waiting list. Child-linked adults in category (b)(1)(A) will be placed ahead of child-linked adults in category (b)(1)(B) on the waiting list.

(B) Within each category, persons for whom application is being made who are determined to be eligible will be listed in the order in which completed applications were received by the program.

(C) Each applicant shall be notified of placement on the waiting list. When a vacancy occurs or funds become available, whichever is applicable, persons for whom application is being made shall be enrolled in the order in which they appear on the waiting list.

(c) If there is no funding available and the Board estimates that the program will be closed to new enrollment for six (6) consecutive weeks or more for child-linked adults, the program will so notify applicants on behalf of child-linked adults. The program will apply the family parent contributions to the family child contributions for that household unless the applicant request a refund of the family parent contributions. The program shall refund the applicant's family parent contributions if there is no subscriber child in the household. When funds become available, the program will notify these applicants that the program is opening for new enrollment. To request coverage when the program opens for new enrollment, an applicant who previously applied for enrollment for a childlinked adult when the program was closed to new enrollment for six (6) consecutive weeks or more will be required to submit a new application pursuant to Section 2699.6600.

(d) If there is funding available, or there is no funding available for coverage of child-linked adults but the Board estimates that the program will be closed to such new enrollment for less than six (6) consecutive weeks, the application shall be reviewed for completeness pursuant to Section 2699.6606.

NOTE: Authority cited: Sections 12693.21 and 12693.755, Insurance Code. Reference: Sections 12693.21 and 12693.755, Insurance Code.

2699.6606. Review of Applications for Completeness.

(a) All applications and Add a Person Forms shall be reviewed for completeness, except for applications, Add a Person Forms, and

documentation solely applicable to childlinked adults if there is no funding available and the Board estimates that the program will be closed to new enrollment for six (6) consecutive weeks or more.

(b) An application that is complete except for documentation required by Section 2699.6600(c)(1)(T) shall be considered complete.

(1) If the application is incomplete, a telephone call will be placed to the applicant to request the missing information and documentation. If the applicant is reached, the applicant will be asked to provide the necessary information and documentation. If the applicant is not reached by telephone, a notice indicating the required information and documentation will be mailed. The applicant must provide all information and documentation necessary for the application to be complete within seventeen (17) calendar days from the date the application was received by the program, and the applicant will be so notified.

(2) If the application submitted is not complete and it is not completed within seventeen (17) calendar days, the application shall be denied. The applicant shall be sent a notice indicating that their application is denied on the basis that the program could not make an eligibility determination because of missing information or documentation.

(3) If the application is complete or is completed within seventeen (17) calendar days, it will be reviewed for an eligibility determination.

NOTE: Authority cited: Sections 12693.21 and 12693.755, Insurance Code. Reference: Section 12693.21, Insurance Code.

2699.6607. Determination of Eligibility.

(a) Except as specified in Section 2699.6605, the program shall complete the application review process within ten (10) calendar days of receipt of the complete application or Add a Person Form unless the program is waiting for necessary information pursuant to Subsection 2699.6606 (b)(1) and (2). For those applications, the program shall complete the application review process within twenty (20) calendar days of receipt of the original application or Add a Person Form.

(1) The program shall determine eligibility for each person age 18 or under based upon the criteria specified in Insurance Code Sections 12693.70, 12693.73 and 12693.76 and this section.

(2) The program shall determine eligibility for each person age 19 and over based on the criteria specified in this section. Notwithstanding any other provision of this Chapter, the first date on which any person age 19 or over shall be eligible for the program is the parental coverage start date. In addition to the criteria applicable to all potential subscribers, to be a child-linked adult eligible to participate in the program, a person age 19 or over must meet all the following requirements:

(A) Is not eligible for no-cost full-scope, or pregnancy-related, Medi-Cal or Medicare Part A and B at the time of enrollment in the program.

(B) Is a resident of the State of California pursuant to Section 244 of the Government Code; or is physically present in California and entered the state with a job commitment or to seek employment.

(C) Is in a family with an annual or monthly household income after income deductions of up to and including 200 percent of the federal poverty level. Any income deduction that is applicable to a child under Medi-Cal shall be applied in determining the annual or monthly household income.

(D) If a person age 19 or over for whom enrollment in the program is requested has an annual or monthly household income after income deductions of 100 percent of the federal poverty level or below, a letter or Notice of Action from the County Welfare Office issued within the last two (2) months must state that the individual is not eligible for no-cost Medi-Cal for a reason other than:

1. failure to provide information requested by Medi-Cal or

2. termination from no-cost Medi-Cal at his or her own request.

(E) Notwithstanding 2699.6607(a)(2)(D), legal guardians applying to the program for coverage with an annual household income after income deductions of 100 percent of the federal poverty level or below do not need to provide a Notice of Action from the County Welfare Office.

(F) Meets the definition of child-linked adult as defined in

Section 2699.6500.

(G) Has a qualifying event as defined in Section 2699.6500 or applies pursuant to Section 2699.6631 for the first year following the parental coverage start date.

(3) If the program does not have the documentation required by Subsection 2699.6600(c)(1)(~~S~~T), the person shall be temporarily deemed to meet citizenship or immigration criteria until such documentation is submitted or until the time for submitting documentation established in Subsection 2699.6600(c)(1)(~~S~~T) has expired, whichever is sooner.

(b) The program shall disregard any stepparent's income in determining income eligibility for a stepchild.

(c) The program shall disregard any child's income in determining income eligibility for any other person.

(d) If any persons for whom application is being made currently have employer sponsored health coverage, these persons shall be determined ineligible. If employer sponsored health coverage was terminated for any persons for whom application is being made within the last three (3) months, these persons shall be determined ineligible, unless the reason for the termination is one of the following:

(1) The person through whom the employer sponsored coverage had been available either

(A) lost employment or experienced a change in employment status,

(B) changed address to a zip code that is not covered by the employer-sponsored coverage,

(C) lost health benefits because the person's employer discontinued health benefits to all employees or dependents, or ceased to provide coverage or contributions for one or more categories of employees or dependents, or

(D) lost coverage because of death of the individual through whom the children or child-linked adults were covered, or a legal separation or divorce from the individual through whom the children or child-linked adults were covered.

(2) The person for whom application is being made was covered under

a COBRA policy, and the COBRA coverage period has ended.

(3) The person for whom application is being made had coverage provided under an exemption authorized under subdivision (i) of Section 1367 of the Health and Safety Code.

(e) (1) Subject to paragraph (2) below, an alien shall only be eligible for the program if the alien is a qualified alien.

(2) (A) In any fiscal year that the annual Budget Act provides the necessary funding, a person who is a qualified alien shall not be determined ineligible solely on the basis on his or her date of entry into the United States. If the annual Budget Act does not provide the necessary funding, and except as provided in subparagraph (B) below, person who is a qualified alien and who entered or enters the United States on or after August 22, 1996, is not eligible for a period of five years beginning on the date of the alien's entry into the United States with a status within the meaning of the term qualified alien.

(B) The limitation under paragraph (2)(A) above shall not apply to the following aliens:

1. An alien who is admitted to the United States as refugee under Section 207 of the Immigration and Naturalization Act (INA).

2. An alien who is granted asylum under Section 208 of the INA.

3. An alien whose deportation is being withheld under Section 243(h) of the INA (8 U.S.C. Section 1230(h)) (as in effect immediately before the effective date (April 1, 1997) of Section 307 of Division (C) of Public Law 104-208) or Section 241(b)(3) of the INA (8 U.S.C. Section 1251(b)(3) (as amended by Section 305(a) of Division C of Public Law 104-208).

4. An alien who is a Cuban and Haitian entrant as defined in Section 501(e) of the Refugee Education Assistance Act of 1980.

5. An alien admitted to the United States as an Amerasian immigrant as described in Section

1612(a)(2)(A)(v.) of Title 8 of the United States Code.

6. An alien who is lawfully residing in any state and is any of the following:

a. A veteran (as defined in Section 101, 1101, or 1301, or as described in Section 107 of Title 38 of the United States Code) with a discharge characterized as an honorable discharge and not on account of alienage and who fulfills the minimum active-duty service requirement of Section 5303A(d) of Title 38 of the United States Code.

b. On active duty (other than active duty for training) in the Armed Forces of the United States.

c. The spouse or unmarried dependent child of an individual described in subparagraph a. or b. or the unremarried surviving spouse of an individual described in subparagraph a. or b. who is deceased if the marriage fulfills the requirements of Section 1304 of Title 38 of the United States Code.

(3) The program shall verify the status of any person for whom application is being made to confirm that the person is a citizen, a non-citizen national of the United States, or a qualified alien.

(f) If application was made pursuant to Section 2699.6603(d), eligibility is contingent upon receipt by the program of documentation of the child's birth within thirty (30) days of the birth.

(g) Applicants will be notified in writing of the eligibility determination for each person applied for. If a person is determined ineligible the notice shall include the reason for the determination of ineligibility and an explanation of the appeal process. The family contribution for any persons determined ineligible which was included with the application shall be refunded. If appropriate, and if permission is given by the applicant, the application shall be forwarded to the Medi-Cal program for eligibility determination.

NOTE: Authority cited: Sections 12693.21 and 12693.755, Insurance Code.
Reference: Sections 12693.21, 12693.70, 12693.71, 12693.73 and 12693.755, Insurance

Code.

2699.6608 Enrollment of AIM Infants.

(a) An AIM infant shall be enrolled when the program receives the required family child contribution beginning with the first full month of coverage pursuant to Section 2699.6613(g), and the following information about the infant from the AIM infant's mother at any time through the end of the eleventh month following the month of birth:

(1) Name; and

(2) Date of birth; and

(3) Sex.

(b) The program shall request information from the AIM infant's mother, on the AIM infant's weight at birth and primary care provider.

(c) In lieu of reporting by the AIM infant's mother, the program must also accept the information specified in subsections (a) and (b) from the AIM infant's mother's health plan or a health care provider that provided services to the AIM infant's mother or the AIM infant.

(d) Upon receipt of the family child contribution and the information specified in subsection (a), the program shall automatically enroll the infant in the same health plan within the Healthy Families Program that the AIM infant's mother is enrolled in through the AIM program.

(e) Automatic enrollment of AIM infants is subject to payment of family child contributions and timely notification of the infant's birth as provided in (a).

(f) Notwithstanding subsection (a) of this section, infants in need of immediate health care services will be immediately enrolled in the program if: (1) the AIM infant's mother's health plan notifies the program in writing of the need for services and provides the information specified in subsection (a) of this section; and (2) this written notification occurs no later than the 10^{th} day of the second full calendar month of the infant's life. For infants enrolled pursuant to this subsection (f), the required family child contribution shall be billed to the AIM mother. If the required family child contribution is not paid, the provisions of this article concerning disenrollment for failure to pay the required family child contribution shall govern.

NOTE: Authority cited: Sections 12693.21 and 12693.755, Insurance Code.

Reference: Sections 12693.21, 12693.70, 12693.71, 12693.73 and 12693.755 and 12693.765, Insurance Code.

2699.6609. Change of Address.

An applicant shall notify the program in writing within thirty (30) days of any change of the applicant's billing address or any change of residence of a person participating in the program.

NOTE: Authority cited: Section 12693.21, Insurance Code.
Reference: Section 12693.21, Insurance Code.

2699.6611. Disenrollment.

(a) A subscriber shall be disenrolled from participation in the program if any of the following occur:

(1) The subscriber is found by the program to no longer be eligible during the annual eligibility review period.

(2) The subscriber child attains the age of 19. A subscriber child who attains the age of 19 will not be disenrolled from the program if he or she applies to the program pursuant to Section 2699.6600 and is determined to be eligible for the program as a subscriber parent pursuant to Section 2699.6607 before his or her effective date of disenrollment.

(3) A subscriber is determined by the program to not be a citizen, non-citizen national, or a qualified alien eligible to participate in the program or fails to provide documentation required pursuant to Subsection 2699.6600(c)(1)(T) within the required time period.

(4) The applicant fails to pay the required family contribution for the subscriber for two (2) consecutive calendar months.

(5) The applicant so requests in writing on behalf of himself or herself or on behalf of another subscriber for whom he or she applied.

(6) The applicant has intentionally made false declarations in order to establish program eligibility for any person.

(7) The applicant fails to provide the necessary information for the subscriber to be requalified.

(8) Death of a subscriber.

(9) The child through whom the subscriber parent became eligible as a child-linked adult as defined in Section 2699.6500 is no longer enrolled in no-cost Medi-Cal and has not enrolled in the program.

(10) The child through whom the subscriber parent became eligible as a child-linked adult as defined in Section 2699.6500 did not enroll in no-cost Medi-Cal, or the program, and the subscriber parent has no other children enrolled in the program or no-cost Medi-Cal.

(11) The child through whom the subscriber parent became eligible as a child-linked adult as defined in Section 2699.6500 attains the age of 19 and the subscriber parent has no other children enrolled in the program or no cost Medi-Cal.

(12) The child through whom the subscriber parent became eligible as a child-linked adult as defined in Section 2699.6500 no longer lives with the subscriber parent and another adult with whom the child now lives applies and is found eligible for enrollment as a child-linked adult through the same child.

(13) The child through whom the subscriber parent became eligible as a child-linked adult as defined in Section 2699.6500 is no longer enrolled in the program, and the subscriber parent has no other children enrolled in the program or no-cost Medi-Cal.

(b) Prior to disenrolling a subscriber pursuant to (a)(4), the program shall provide written notification to the applicant no less than thirty (30) days prior to disenrollment. Such notice shall clearly indicate all of the following:

(1) The disenrollment will not occur if payment in full is made as required.

(2) If disenrollment for non-payment occurs, coverage will be terminated at the end of the second consecutive month for which the family contribution was not paid.

(c) When a subscriber is disenrolled pursuant to (a) above, the program shall notify the applicant of the disenrollment. The notice shall be in writing and include the following information:

(1) The reason for the disenrollment.

(2) The effective date of disenrollment.

(3) The final day of coverage provided through the program.

(4) An explanation of the appeals process including the right to request continued enrollment pursuant to Section 2699.6612.

(d) Disenrollment pursuant to (a)(4) shall be effective as of the end of the second consecutive calendar month for which the required monthly contributions were not paid in full.

(e) Disenrollment pursuant to (a)(7) shall be effective at the end of the month of the subscriber's anniversary date.

(f) Disenrollment pursuant to (a)(1) shall be effective two (2) months after the end of the month of the subscriber's anniversary date if the subscriber is no longer eligible for the program because his or her household income is below the program guidelines. Otherwise, disenrollment pursuant to (a)(1) shall be effective at the end of the month of the subscriber's anniversary date.

(g) Disenrollment pursuant to (a)(3) shall be effective at the end of the calendar month in which the conclusion of the two-month period falls pursuant to Subsection 2699.6600(c)(1)(T).

(h) Disenrollment pursuant to (a)(5) shall be effective at the end of the month in which the applicant's request was received. The applicant will be notified of the amount of family contribution due to the program for coverage through the subscriber's effective date of disenrollment.

(i) Disenrollment pursuant to (a)(6) shall be effective at the end of the month in which the determination was made.

(j) Disenrollment pursuant to (a)(2) and (a)(11) shall be effective on the last day of the month the subscriber child or the child through whom the subscriber parent became eligible as a child-linked adult attains the age of 19.

(k) Disenrollment pursuant to (a)(8) shall be effective at the end of the month in which death occurred.

(l) Disenrollment pursuant to (a)(9) shall be effective at the end of the month following the program's notification of the subscriber child's disenrollment from no-cost Medi-Cal.

(m) Disenrollment pursuant to (a)(10) shall be effective at the end of the month following the second month from the date in which the application was received.

(n) Disenrollment pursuant to (a)(12) shall be effective at the end of the month following the program's determination that the subscriber child has departed from the subscriber parent's household and is living with another adult who has applied for enrollment and is eligible as a child-linked adult through that same child.

(o) Disenrollment pursuant to (a)(13) shall be effective at the end of the month following the program's determination that the adult is no longer child linked.

NOTE: Authority cited: Sections 12693.21 and 12693.755, Insurance Code. Reference: Sections 12693.21, 12693.45, 12693.74, 12693.77, 12693.755, 12693.98 and 12693.981, Insurance Code.

Section 2699.6612. Appeals.

(a) The following program decisions may be appealed to the board:

(1) A decision that an individual is not qualified to participate or continue to participate in the program.

(2) A decision that an individual is not eligible for enrollment or continuing enrollment in the program.

(3) A decision as to the effective date of coverage.

(b) An appeal shall be filed in writing with the program within sixty (60) calendar days of the date of the notice of the decision being appealed.

(c) Appeals shall be reviewed pursuant to the following process:

(1) First level appeals shall be filed with the program, and the program shall make a determination on the appeal within thirty (30) calendar days from receipt of the appeal. The program shall notify the appellant in writing of the program's decision and that he or she may request a second level review by the Exceutive Director.

(2) Second level appeals shall be filed with the Executive Director within thirty (30) calendar days of the date of the notice of the determination concerning the first level appeal. The program may contact the appellant to get clarification and additional information to make a determination. The program shall notify the appellant in writing of the Executive Director's decision and that he or she may request an administrative hearing.

(3) As determined by the program, an administrative hearing shall be conducted by an Administrative Law Judge employed by the Office of Administrative Hearings pursuant to the provisions of Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code, or pursuant to the pre-and post-hearing procedures set forth in Article 3 (commencing with Section 1140) of Chapter 2 of Division 2 of Title 1 of the California Code of Regulations as modified by Section 12693.89 of the Insurance Code. Requests for administrative hearings shall be filed with the program within thirty (30) calendar days of receipt of the determination concerning the second level appeal.

(d) An appeal shall include all of the following:

(1) A copy of any decision being appealed, or a written statement of the action or failure to act being appealed.

(2) A statement describing the issues that are being disputed.

(3) A statement describing the program statute, regulation, or other written representation of program policy that the program or board violated.

(4) A statement of the resolution being requested.

(5) Any other relevant information.

(e) An appellant may request continued enrollment while the appeal is being determined. The enrollment shall continue until a determination is made. Family contributions and copays are required during the continued enrollment period. An appeal that requests continued enrollment shall:

(1) Be limited to appeals filed pursuant to subsection (c)(1) of this section.

(2) Be filed in writing with the program within fifteen (15) calendar days of the date the notice of the decision being appealed.

(3) Meet all other requirements described in this section.

NOTE: Authority cited: Sections 12693.21 and 12693.41, Insurance Code. Reference: Sections 12693.85, 12693.86, 12693.87, and 12693.89, Insurance Code and 42 CFR Section 457.1170.

2699.6613. Starting Date of Coverage For Subscribers.

(a) Coverage shall begin for subscribers no later than ten (10) calendar days

from the date the person is determined to be eligible unless any of the following applies:

(1) A person for whom application is being made is eligible for continued eligibility under no-cost, full scope Medi-Cal and that eligibility will continue for more than ten (10) calendar days from the date the person is determined to be eligible.

(2) Application is being made on behalf of a child less than 12 months of age for coverage to begin on the child's first birthday pursuant to Section 2699.6603(a).

(3) Application is being made on behalf of a child who is currently enrolled in the Medi-Cal 133 percent program.

(4) Application is being made on behalf of a newborn prior to birth.

(5) Payment of in arrears family contributions is required prior to enrollment of the person pursuant to Section 2699.6600(a)(4) or (5).

(6) The subscriber is an AIM infant.

(b) Coverage shall begin for subscribers under (a)(1) on the first day after the end of the subscriber's continued eligibility period under Medi-Cal.

(c) Coverage shall begin for subscribers under (a)(2) on their first birthday.

(d) Coverage shall begin for subscribers under (a)(3) on their sixth birthday.

(e) Coverage shall begin for subscribers under (a)(4) no less than eleven (11) calendar days but within thirteen (13) calendar days after the program receives documentation of the birth.

(f) Coverage shall begin for subscribers under (a)(5) no later than thirteen 13 calendar days from the date the program receives a payment for the complete amount of family contributions owed by the applicant.

(g) Coverage shall begin for subscribers pursuant to (a)(6) on the infant's date of birth.

(h) The program shall notify applicants in writing of the effective date of coverage for all persons determined to be eligible.

NOTE: Authority cited: Section 12693.21, Insurance Code.
Reference: Sections 12693.21, Insurance Code.

2699.6617. Additional Enrollments.

(a) To apply to the program for additional persons, the applicant shall submit an application pursuant to Section 2699.6600 or the "Add a Person Form" (HF FM 067 EN, 11/17/2003), which requests information pursuant to Section 2699.6600(b), 6600(c)(1)(A), (D), (F)1., (F)3., (F)11., (F)15., (I), (K), (L), (R), (S), and (T).

(b) Eligibility for the program will be determined pursuant to Section 2699.6607.

(c) The "Add a Person Form" (HF FM 067 EN,11/17/2003), is hereby incorporated by reference.

NOTE: Authority cited: Section 12693.21, Insurance Code.
Reference: Section 12693.21, Insurance Code.

2699.6619. Transfer of Enrollment.

(a) A subscriber shall be transferred from one participating health, dental, or vision plan to another if any of the following occurs:

(1) The applicant so requests in writing because the subscriber no longer resides in an area served by the participating plan in which the subscriber is enrolled, and there is at least one participating plan serving the area in which the subscriber now resides.

(A) If the program learns that the subscriber no longer resides in an area served by the participating health plan in which the subscriber is enrolled, but the applicant does not choose a new health plan within thirty (30) days of a written notice from the program, the program will enroll the subscriber in the Community Provider Plan in the subscriber's county of residence.

(B) If the program learns that the subscriber no longer resides in an area served by the participating dental plan in which the subscriber is enrolled, but the applicant does not choose a new dental plan within thirty (30) days of a written notice from the program, the program will enroll the subscriber in a participating dental plan in the subscriber's county of residence. If there is more than one (1) participating dental plan in the subscriber's county of residence, the program will alternate assignments between the participating dental plans so that the transfers are evenly distributed among the participating dental plans.

(C) If the program learns that the subscriber no longer resides in an area served by the participating vision plan in which the subscriber is enrolled, but the applicant does not choose a new vision plan within thirty (30) days of a written notice from the program, the program will enroll the subscriber in a participating vision plan in the subscriber's county of residence. If there is more than one (1) participating vision plan in the subscriber's county of residence, the program will alternate assignments between the participating vision plans so that the transfers are evenly distributed among the participating vision plans.

(2) The applicant or the participating plan so requests in writing because of failure to establish a satisfactory subscriber-plan relationship and the Executive Director of the Board or designee determines that the transfer is in the best interests of the subscriber and the program, and there is at least one other participating plan serving the area in which the subscriber resides.

(3) The program contract with the participating plan in which the subscriber is enrolled is canceled or not renewed.

(A) If the applicant does not choose a new health plan in response to two (2) written notices and three (3) phone calls from the program by the necessary date of transfer, the program will enroll the subscriber in the Community Provider Plan in the subscriber's county of residence.

(B) If the applicant does not choose a new dental plan in response to two (2) written notices and three (3) phone calls from the program by the necessary date of transfer, the program will enroll the subscriber in a participating dental plan in the subscriber's county of residence. If there is more than one (1) participating dental plan in the subscriber's county of residence, the program will alternate assignments between the participating dental plans so that the transfers are evenly distributed among the participating dental plans.

(C) If the applicant does not choose a new vision plan in response to two (2) written notices and three (3) phone calls from the program by the necessary date of transfer, the program will enroll the subscriber in a participating vision plan in the subscriber's county of residence. If there is more than one (1) participating vision plan in the subscriber's county of residence, the program will alternate

assignments between the participating vision plans so that the transfers are evenly distributed among the participating vision plans.

(4) An open enrollment request is submitted pursuant to Section 2699.6621.

(5) An AIM infant subscriber has a sibling(s) that is enrolled in a different health plan and is transferred pursuant to subsection (f).

(b) A subscriber shall be transferred from one participating health plan to another if the applicant so requests in writing once within the first three (3) months from the original effective date of coverage in the program, or the applicant so requests in writing once within the first thirty (30) days from the effective date of coverage in a new plan following open enrollment, for any reason.

(c) A subscriber shall be transferred from one participating dental or vision plan to another if the applicant so requests in writing once within the first thirty (30) days from the original effective date of coverage in the program, or the applicant so requests in writing once within the first thirty (30) days from the effective date of coverage in a new plan following open enrollment, for any reason.

(d) If a subscriber is transferred pursuant to (a), (b), or (c) above, all other subscribers of the same applicant who live in the same household will also be transferred, unless the subscriber was transferred because the subscriber moved from the household.

(e) Transfer of enrollment shall take effect on the first day of a month and shall be within forty (40) days of approval of the request, or, if the transfer is pursuant to subsection (a)(3) above, shall take effect prior to the end of the contract. However, subscribers in inpatient facilities on the scheduled date of transfer shall not be transferred to a new health plan until the first day of the month following completion of their inpatient stay.

(f) The following provisions apply to the transfer of AIM infants from one participating health, dental, or vision plan to another:

(1) An AIM infant subscriber will be automatically transferred to the same health, dental, and vision plan that his or her sibling(s) is enrolled in, effective on the first day of the infant's third calendar month of birth, unless one of the following occurs:

(A) The applicant submits a letter stating that the infant has a physical, developmental, behavioral, or emotional condition that requires continuity of care, and requests that the infant's sibling(s) be transferred to the infant's health plan, or

(B) The applicant submits a letter stating that the infant has a physical, developmental, behavioral, or emotional condition that requires continuity of care, and requests that the infant remain with the current health plan and the sibling(s) remain with his or her current health plan. For siblings enrolled in different health plans, the applicant must choose the same health plan for all children living in the household during the Open Enrollment period after the AIM infant's first birthday.

(2) An AIM infant subscriber shall be transferred from one participating health, dental, or vision plan to another if the applicant so requests in writing once within the first three (3) months from the date of the infant's birth and the infant subscriber has no sibling(s) in the program. The transfer of enrollment shall take effect on the first day of a month and shall be within forty (40) days after the approval of the request but not earlier than the third calendar month of the infant's enrollment in the program.

NOTE: Authority cited: Section 12693.21, Insurance Code.
Reference: Sections 12693.21, 12693.326 and 12693.51, Insurance Code.

2699.6621. Open Enrollment Period.

(a) The program shall provide for an annual open enrollment period of at least forty-five (45) calendar days. During this period, applicants may for any reason request that subscribers be transferred from one participating health, dental, or vision plan to another. Plan selection rules set forth in Section 2699.6623 apply for open enrollment.

(b) For each subscriber for whom an applicant is requesting to change plans during an open enrollment period, the applicant shall provide the following:

(1) Full name

(2) Address

(3) Social Security Number (optional)

(4) Home telephone number

(5) Current participating plan(s)

(6) New participating plan(s)

(7) The applicant's choice of primary care provider/clinic (optional) and dentist (optional) for each child for whom application is being made.

(8) A declaration that the applicant understands that a change of participating plans may result in a change in the required family contribution.

NOTE: Authority cited: Section 12693.21, Insurance Code. Reference: Sections 12693.21, 12693.51, Insurance Code.

2699.6623. Choosing Plans.

(a) If all persons for whom the applicant applies live in the same household, the applicant shall enroll all persons in the same participating health plan, the same participating dental plan, and the same participating vision plan.

(b) If the persons for whom the applicant applies live in more than one household, the applicant shall enroll all persons living in each household in the same participating health plan, the same participating dental plan and the same participating vision plan.

NOTE: Authority cited: Section 12693.21, Insurance Code.
Reference: Sections 12693.21, Insurance Code.

2699.6625. Annual Eligibility Review for Subscribers.

(a) Except as specified in (b), each subscriber will be re-evaluated annually prior to their anniversary date in the program to determine continued eligibility for the program. Applicants shall be notified of the annual eligibility review process at least sixty (60) calendar days prior to the anniversary date.

(b) If subscribers for whom an applicant has applied have different anniversary dates, the annual eligibility review will be based on the anniversary date of the last subscriber to be enrolled, except as described in Subsection 2699.6631(e).

(c) To requalify, an applicant must provide to the program all of the following information which is required to reestablish eligibility: the applicant's name and account number as stated on their billing statement; name and

address of each enrolled person, documentation of gross income of each enrolled person's household as described in Subsection 2699.6600(c)(1)(K), documentation of court ordered child support, and/or alimony paid, and child care and/or disabled dependent care expenses paid in order to determine income deductions as described in Subsection 2699.6600(c)(1)(L), an indication of any pregnant family member living in the home and her expected due date, and a statement indicating which person(s) is currently enrolled in an employer sponsored health insurance plan. To avoid a break in coverage, all required information must be submitted at least ten (10) calendar days before the end of the month in which the anniversary date falls.

(d) Continued eligibility will be determined pursuant to Section 2699.6607.

(e) Unless disenrolled pursuant to Section 2699.6611, persons shall continue to be considered eligible for the program for one year from the effective date of coverage, or if a later annual eligibility review date is established under (b), until that date.

NOTE: Authority cited: Section 12693.21, Insurance Code.
Reference: Sections 12693.21, 12693.74 Insurance Code.

2699.6629. Payment for Application Assistance.

(a) The program shall pay an application assistance fee to an eligible entity that assists an applicant in completing a program application or assists an applicant in completing annual eligibility review, if the following conditions are met:

(1) A child or a child-linked adult are enrolled or requalified as a result of the application;

(2) The request for payment is made in writing and specifies the entity to which the payment shall be made and includes:

(A) The certified application assistant identification number of the person who assisted the applicant.

(B) The entity identification.

(3) The application includes a signed and dated declaration by the applicant stating that the certified application assistant helped the applicant complete the application.

(4) The certified application assistant has successfully completed a state-sponsored or approved training course, which may include continuing education courses.

(b) The following entities are eligible to receive application assistance fees:

(1) an insurance agent as defined in Section 31 of the Insurance Code, or a broker as defined in Section 33 of the Insurance Code;

(2) a licensed health care provider;

(3) a tax preparer as defined in Section 22251 (a)(1)(A) of the Business and Professions Code;

(4) a licensed health care institution;

(5) a licensed health care clinic;

(6) a county department of public health, a city health department, or a county department that delivers health services;

(7) an Indian Health Service Facility;

(8) a school;

(9) a faith-based organization;

(10) a licensed day-care provider;

(11) a direct state Maternal and Child Health Contractor;

(12) a WIC Supplemental Food and Nutrition program for Women, Infants and Children;

(13) a Parent Teacher Organization;

(14) An organization meeting all of the following criteria:

(A) The organization has significant interaction with children or parents of children who represent the target market for the program or for children's Medi-Cal;

(B) The organization is not a licensed health, dental or vision plan, or an organization providing health, dental or vision care to children; and

(C) The organization has a federal tax identification number and is a bona fide non-profit entity as determined by the Internal Revenue Service.

(c) An incomplete request will not be processed for reimbursement; missing information cannot be submitted at a later date.

(d) The amount of the application assistance fee shall be as follows:

(1) Fifty ($50.00) dollars per successful application made pursuant to Section 2699.6600 where a child successfully enrolls in no-cost Medi-Cal or the program.

(2) Fifty ($50.00) dollars per successful application made pursuant to Section 2699.6600 where a child-linked adult successfully enrolls in no-cost Medi-Cal or the program when a request for enrollment is made at the same time for the child through whom the subscriber parent became eligible as a child-linked adult as defined in Section 2699.6500.

(3) If children or child-linked adults on one application are enrolled in no-cost Medi-Cal and the program, a $50.00 payment will be made for each program pursuant to (1) and (2).

(4) Payment will only be made on one successful application for no-cost Medi-Cal and one successful application for the program per enrollment entity for a household in a year.

(5) Twenty-five ($25.00) dollars for a successful Annual Eligibility Review for the program.

(e) The program shall monitor the payment of application assistance fees to assure the integrity of the process.

(1) The program may determine at any time that an individual will no longer be eligible to be a certified application assistant and/or an entity will no longer be eligible to receive application assistance fees.

(2) Notice of such determination shall be provided within five (5) calendar days.

(f) Entities applying for application assistance fees and certified application assistants are prohibited from assisting applicants in choosing a health, dental, or vision plan for persons for whom application is being made. The person or entity may direct the applicant to that part of the program

materials that describes health, dental, and vision plans. Nothing in this subdivision shall be construed to prohibit an application assistant or entity from providing factual information comparing, contrasting, and explaining the differences between plans and/or provider networks when assisting an applicant. In no instance may an application assistant or entity suggest which plan or provider an applicant should choose.

(g) Participating dental and vision plans shall be prohibited from directly, indirectly, or through their agents conducting in-person, door-to-door, mail, or phone solicitation of applicants for enrollment, or from assisting applicants to apply for the program except as permitted by California Insurance Code Section 12693.325.

(h) Participating health plans shall be prohibited from directly, indirectly, or through their agents conducting in-person, door-to-door, mail, or phone solicitation of applicants for enrollment, or from assisting applicants to apply for the program except as permitted by California Insurance Code Section 12693.325.

(i) Nothing in this section shall prohibit licensed health, dental or vision care providers who are not claiming an application assistance fee from otherwise distributing program applications and providing assistance to applicants.

NOTE: Authority cited: Sections 12693.21 and 12693.755, Insurance Code.
Reference: Sections 12693.21, 12693.32, 12693.325 and 12693.755, Insurance Code.

2699.6631. Initial Enrollment Period for Child-linked Adults.

There shall be an initial enrollment period for child linked adults ending one year after the parental coverage start date. Thereafter, enrollment may only occur at a qualifying event as defined in Section 2699.6500.

(a) The program shall provide notification to the applicants of subscriber children enrolled prior to the parental coverage start date in households with incomes at or below 200 percent of the federal poverty level. Notification shall be sent to the address on record and shall include an explanation of program expansions to include child-linked adults, and instructions to complete and return to the program the form provided by the program, documentation of citizenship or immigration status pursuant to 2699.6600(c)(1)(T), and the appropriate family contribution for enrollment.

(b) For the first year following the parental coverage start date, for all applications for the program for children only where one or more children enrolled in the program live in households with incomes at or below 200 percent of the federal poverty level, the applicant shall be notified of program expansions to include child-linked adults and shall be provided the opportunity to submit the additional information to the program. The notification shall include instructions to complete and return to the program the form provided by the program, documentation of citizenship or immigration status pursuant to 2699.6600(c)(1)(T), and the appropriate family contribution for enrollment.

(c) For the first year following the parental coverage start date, the applicant shall be provided the opportunity to submit the form provided by the program pursuant to this section and the appropriate family contribution. Beginning one year after the parental coverage start date, applicants must use an application or an Add a Person Form to request enrollment for a child or child-linked adult in the program.

(d) Except as provided in this section, the program shall determine eligibility and enroll child-linked adults pursuant to the process established for application to the program.

(e) Notwithstanding Section 2699.6625(e), the annual eligibility review date for the subscriber parent enrolled pursuant to Section 2699.6631 shall be the same as for the subscriber child through whom the subscriber parent became eligible.

NOTE: Authority cited: Sections 12693.21 and 12693.755, Insurance Code.
Reference: Sections 12693.21 and 12693.755, Insurance Code.

ARTICLE 3: HEALTH, DENTAL AND VISION BENEFITS

2699.6700. Scope of Health Benefits.

(a) The basic scope of benefits offered by participating health plans must comply with all requirements of the Knox-Keene Health Care Service Plan Act of 1975 including amendments as well as its applicable regulations, and shall include all of the benefits and services listed in this section, subject to the exclusions listed in this section and Section 2699.6703. No other benefits shall be permitted to be offered by a participating health plan as part of the program. The basic scope of benefits shall include:

(1) Health Facilities

(A) Inpatient Hospital Services: General hospital services, in a room of two or more, with customary furnishings and equipment, meals (including special diets as medically necessary), and general nursing care. All medically necessary ancillary services such as:use of operating room and related facilities; intensive care unit and services; drugs, medications, and biologicals; anesthesia and oxygen; diagnostic laboratory and x-ray services; special duty nursing as medically necessary; physical, occupational, and speech therapy , respiratory therapy; administration of blood and blood products; other diagnostic, therapeutic and rehabilitative services as appropriate; and coordinated discharge planning, including the planning of such continuing care as may be necessary.

Inpatient hospital services. This includes coverage for general anesthesia and associated facility charges, in connection with dental procedures when hospitalization is necessary because of an underlying medical condition or clinical status or because of the severity of the dental procedure. This benefit is only available to subscribers under seven years of age; the developmentally disabled, regardless of age; and subscribers whose health is compromised and for whom general anesthesia is medically necessary, regardless of age. Participating health plans shall coordinate such services with the subscriber’s participating dental plan. Services of the dentist or oral surgeon are excluded for dental procedures.

Exclusions: Personal or comfort items or a private room in a hospital are excluded unless medically necessary.

(B) Outpatient Services: Diagnostic, therapeutic and surgical services performed at a hospital or outpatient facility. Includes: physical, occupational, and speech therapy as appropriate; and those hospital services which can reasonably be provided on an ambulatory basis. Related services and supplies in connection with these services including operating room, treatment room, ancillary services, and medications which are supplied by the hospital or facility for use during the subscriber's stay at the facility.

General anesthesia and associated facility charges, and outpatient services in connection with dental procedures when the use of a hospital or surgery center is necessary because of an underlying medical condition or clinical status or because of the severity of the dental procedure. This benefit is only available to subscribers under seven years of age; the developmentally disabled, regardless of age; and subscribers whose health is compromised and for whom general anesthesia is medically necessary, regardless of age.

Participating health plans shall coordinate such services with the subscriber's participating dental plan. Services of the dentist or oral surgeon are excluded for dental procedures.

(2) Professional Services: Medically necessary professional services and consultations by a physician or other licensed health care provider acting within the scope of his or her license. Surgery, assistant surgery and anesthesia (inpatient or outpatient); inpatient hospital and skilled nursing facility visits; professional office visits including visits for allergy tests and treatments, radiation therapy, chemotherapy, and dialysis treatment; and home visits when medically necessary. In addition, professional services include:

(A) Eye examinations: For subscriber children, eye refractions to determine the need for corrective lenses, and dilated retinal eye exams. For subscriber parents, eye refraction is optional for plan.

(B) Hearing tests, hearing aids and services: Audiological evaluation to measure the extent of hearing loss and a hearing aid evaluation to determine the most appropriate make and model of hearing aid.

Hearing aid: Monaural or binaural hearing aids including ear mold(s), the hearing aid instrument, the initial battery, cords and other ancillary equipment. Visits for fitting, counseling,
adjustments, repairs, etc., at no charge for a one-year period following the provision of a covered hearing aid.

Limitation: For subscriber parents, this benefit is limited to a maximum of $1000 per member every thirty-six months for the hearing instrument and ancillary equipment.
Exclusions: The purchase of batteries or other ancillary equipment, except those covered under the terms of the initial hearing aid purchase and charges for a hearing aid which exceeds specifications prescribed for correction of a hearing loss.

Replacement parts for hearing aids, repair of hearing aid after the covered one-year warranty period, replacement of a hearing aid more than once in any period of thirty-six months, and surgically implanted hearing devices.

(C) Immunizations for subscriber children: Immunizations consistent with the most current version of the Recommended Childhood Immunization Schedule/United States adopted by the Advisory Committee on Immunization Practices (ACIP). Immunizations required for travel as recommended by the ACIP, and other age appropriate immunizations as recommended by the ACIP.

Immunizations for subscriber parents: Immunizations for adults as recommended by the ACIP. Immunizations required for travel as recommended by the ACIP. Immunizations such as Hepatitis B for individuals at occupational risk, and other age appropriate immunizations as recommended by the ACIP.

(D) Periodic health examinations: For subscriber children, periodic health examinations, including all routine diagnostic testing and laboratory services appropriate for such examinations consistent with the most current Recommendations for Preventative Pediatric Health Care, as adopted by the American Academy of Pediatrics; and the most current version of the Recommended Childhood Immunization Schedule/United States, adopted by the Advisory Committee on Immunization Practices (ACIP).

The frequency of such examinations shall not be increased for reasons which are unrelated to the medical needs of the subscriber including: a subscriber's desire for physical examinations; or reports or related services for the purpose of obtaining or maintaining employment, licenses, insurance, or a school sports clearance.

Periodic Health Examinations for subscriber parents: Periodic health examinations including all routine diagnostic testing and laboratory services appropriate for such examinations. This includes coverage for the screening and diagnosis of prostate cancer including but not limited to, prostate-specific antigen testing and digital rectal examination, when medically necessary and consistent with good medical practice. The frequency of such examinations shall not be increased for reasons which are unrelated to the medical needs of the subscriber including: a subscriber's desire for physical examinations; or reports or related services for the purpose of obtaining or maintaining employment, licenses, insurance, or a school sports clearance.

(E) Well baby care during the first two years of life, including newborn hospital visits, health examinations and other office visits.

(3) Diagnostic X-ray and Laboratory Services: Diagnostic laboratory services, diagnostic and therapeutic radiological services necessary to appropriately evaluate, diagnose, treat, and follow-up on the care of subscribers. Other diagnostic services, which shall include, but not be limited to, electrocardiography, electro-encephalography, and mammography for screening or diagnostic purposes. Laboratory tests appropriate for the management of diabetes, including at a minimum: cholesterol, triglycerides, microalbuminuria, HDL/LDL and Hemoglobin A-1C (Glycohemoglobin).

(4) Prescription Drugs: Medically necessary drugs when prescribed by a licensed practitioner acting within the scope of his or her licensure. Includes injectable medication and needles and syringes necessary for the administration of the covered injectable medication. Also includes insulin, glucagon, syringes and needles and pen delivery systems for the administration of insulin, blood glucose testing strips, ketone urine testing strips, lancets and lancet puncture devices in medically appropriate quantities for the monitoring and treatment of insulin dependent, noninsulin

dependent and gestational diabetes. Prenatal vitamins and fluoride supplements included with vitamins or independent of vitamins which require a prescription.

Medically necessary drugs administered while a subscriber is a patient or resident in a rest home, nursing home, convalescent hospital or similar facility when prescribed by a plan physician in connection with a covered service and obtained through a plan designated pharmacy.

Health plans may specify that generic equivalent prescription drugs must be dispensed if available, provided that no medical contraindications exist. The use of a formulary, maximum allowable cost (MAC) method, and mail order programs by health plans is encouraged.

Health plans shall provide coverage for one cycle or course of treatment of tobacco cessation drugs per benefit year. The health plan must also require the subscriber to attend tobacco use cessation classes or programs in conjunction with tobacco cessation drugs.

For subscriber parents, plans can require subscribers to pay a portion or all the cost of the smoking cessation classes or programs. Plans can also require the subscriber parent to pay the cost of the smoking cessation drug initially and reimburse the subscriber parent minus the copayment(s) upon the successful completion of a smoking cessation program.

Contraceptive Drugs and Devices: All FDA approved oral and injectable contraceptive drugs and prescription contraceptive devices are covered including internally implanted time release contraceptives such as Norplant.

Exclusions: Experimental or investigational drugs, unless accepted for use by the standards of the medical community; drugs or medications for cosmetic purposes; patent or over-the-counter medicines, including nonprescription contraceptive jellies, ointments, foams, condoms, etc.; medicines not requiring a written prescription order (except insulin and smoking cessation drugs as previously described); and dietary supplements (except for formulas or special food products to treat phenylketonuria or PKU), and appetite suppressants or any other diet drugs or medications.

(5) Durable Medical Equipment: Medical equipment appropriate for use in the home which: 1) is intended for repeated use; 2) is generally not useful to a person in the absence of illness or injury; and 3) primarily serves a medical purpose. The health plan may determine whether to rent or purchase standard equipment. Repair or replacement is covered unless necessitated by misuse or loss. Oxygen and oxygen equipment; blood glucose monitors and blood glucose monitors for the visually impaired as medically appropriate for insulin dependent, non-insulin dependent, and gestational diabetes; insulin pumps and all related supplies; visual aids, excluding eyewear, to assist the visually impaired with proper dosing of insulin, and apnea monitors; podiatric devices to prevent or treat diabetes complications; pulmoaides and related supplies; nebulizer machines, tubing and related supplies, and spacer devices for metered dose inhalers; ostomy bags and urinary catheters and supplies.

Exclusions: Coverage for comfort or convenience items; disposable supplies except ostomy bags and urinary catheters and supplies consistent with Medicare coverage guidelines; exercise and hygiene equipment; experimental or research equipment; devices not medical in nature such as sauna baths and elevators, or modifications to the home or automobile; deluxe equipment; or more than one piece of equipment that serve the same function .

(6) Orthotics and Prosthetics: Orthotics and prosthetics including medically necessary replacement prosthetic devices as prescribed by a licensed practitioner acting within the scope of his or her licensure, and medically necessary replacement orthotic devices when prescribed by a licensed practitioner acting within the scope of his or her licensure. Coverage for the initial and subsequent prosthetic devices and installation accessories to restore a method of speaking incident to a laryngectomy, and therapeutic footwear for diabetics. Also includes prosthetic devices to restore and achieve symmetry incident to mastectomy.

Exclusions: Corrective shoes and arch supports, except for therapeutic footwear and inserts for individuals with diabetes; non-rigid devices such as elastic knee supports, corsets, elastic stockings, and garter belts; dental appliances; electronic voice producing machines; or more than one device for the same part of the body. Also does not include eyeglasses (except for eyeglasses or contact lenses necessary after cataract surgery).

(7) Cataract Spectacles and Lenses: Cataract spectacles, cataract contact lenses, or intraocular lenses that replace the natural lens of

the eye after cataract surgery are covered. Also one pair of conventional eyeglasses or conventional contact lenses are covered if necessary after cataract surgery with insertion of an intraocular lens.

(8) Maternity: Medically necessary professional and hospital services relating to maternity care including: pre-natal and post-natal care and complications of pregnancy; newborn examinations and nursery care while the mother is hospitalized Includes providing coverage for participation in the statewide prenatal testing program administered by the State Department of Health Services known as the Expanded Alpha Feto Protein Program.

(9) Family Planning: Voluntary family planning services including counseling and surgical procedures for sterilization as permitted by state and federal law, diaphragms, and coverage for other federal Food and Drug Administration approved devices and contraceptive drugs pursuant to the prescription drug benefit.

(10) Medical Transportation Services: Emergency ambulance transportation in connection with emergency services to the first hospital which actually accepts the subscriber for emergency care. Includes ambulance and ambulance transport services provided through the “911” emergency response system.

Non-emergency transportation for the transfer of a subscriber from a hospital to another hospital or facility or facility to home when:

(A) medically necessary, and

(B) requested by a plan provider, and

(C) authorized in advance by the participating health plan.

Exclusions: Coverage for transportation by airplane, passenger car, taxi or other form of public conveyance.

(11) Emergency Health Care Services: Twenty-four hour emergency care for a medical condition manifesting itself by acute symptoms of a sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in any of the following:

(A) Placing the patient’s health in serious jeopardy.

(B) Serious impairment to bodily functions.

(C) Serious dysfunction of any bodily organ or part.

This must be provided both in and out of the health plan service area and in and out of the health plan's participating facilities.

(12) Mental Health

(A) Inpatient: Mental health care during a certified confinement in a participating hospital when ordered and performed by a participating mental health professional for the treatment of a mental health condition. For subscriber children determined by their county mental health department to meet the criteria for Serious Emotional Disturbances (SED) of a child or for a serious mental disorder, pursuant to Section 5600.3 of the Welfare and Institutions Code, plans may limit services to 30 days per benefit year. Plans shall be responsible for identifying subscriber children who may be SED or may have a serious mental disorder and shall refer these individuals to their respective county mental health department for determination. For subscriber children who are determined as SED or as having a serious mental disorder by their county mental health department, participating plans shall provide up to 30 days of inpatient care and shall then refer these individuals to their county mental health department for continued treatment of the condition.

Except as limited pursuant to the previous paragraph for subscribers who are determined as SED or as having a serious mental disorder by their county mental health department, plans must provide services with no visit limits for severe mental illnesses including schizophrenia, schizoaffective disorder, bipolar disorder, major depressive disorders, panic disorder, obsessivecompulsive disorder, pervasive developmental disorder or autism, anorexia nervosa, and bulimia nervosa.

Plans may limit coverage to 30 days per benefit year for illnesses that meet neither the criteria for severe mental illnesses, nor the criteria for SED of a child or for a serious mental disorder pursuant to Section 5600.3 of the Welfare and Institutions Code. Plans, with the agreement of the subscriber or applicant or other responsible adult if appropriate, may substitute for each day of inpatient hospitalization any of the following: two (2) days of

residential treatment, three (3) days of day care treatment, or four (4) outpatient visits.

(B) Outpatient: Mental health care when ordered and performed by a participating mental health professional. This includes the treatment of children who have experienced family dysfunction or trauma, including child abuse and neglect, domestic violence, substance abuse in the family, or divorce and bereavement. Family members may be involved in the treatment to the extent the plan determines it is appropriate for the health and recovery of the child.

Plans must provide services with no visit limits for severe mental illnesses, including schizophrenia, schizoaffective disorder, bipolar disorder, major depressive disorders, panic disorder, obsessivecompulsive disorder, pervasive developmental disorder or autism, anorexia nervosa and bulimia nervosa. Plans shall be responsible for identifying subscriber children who may be SED or may have a serious mental disorder and shall refer these individuals to their county mental health department for determination. Notwithstanding the first sentence of this paragraph, participating plans shall refer subscriber children who are determined by their county mental health department as SED or as having a serious mental disorder pursuant to Section 5600.3 of the Welfare and Institutions Code, to their county mental health department for treatment of the condition.

Plans must provide up to 20 visits per benefit year Plans may limit coverage to 20 days per benefit year for illnesses that meet neither the criteria for severe mental illnesses, nor the criteria for SED of a child or a serious mental disorder pursuant to Section 5600.3 of the Welfare and Institutions Code.

Participating plans may elect to provide additional visits. Plans may provide group therapy at a reduced copayment.

(13) Alcohol and Drug Abuse:

(A) Inpatient: Hospitalization for alcoholism or drug abuse as medically appropriate to remove toxic substances from the system.

(B) Outpatient: Crisis intervention and treatment of alcoholism or drug abuse on an outpatient basis as medically appropriate.
Participating health plans shall offer at least 20 visits per benefit year. Participating health plans may elect to provide additional visits.

(14) Home Health Services: Health services provided at the home by health care personnel. Includes visits by Registered Nurses, Licensed Vocational Nurses, and home health aides; physical, occupational and speech therapy; and respiratory therapy when prescribed by a licensed practitioner acting within the scope of his or her licensure.

Home health services are limited to those services that are prescribed or directed by the attending physician or other appropriate authority designated by the plan. If a basic health service can be provided in more than one medically appropriate setting, it is within the discretion of the attending physician or other appropriate authority designated by the plan to choose the setting for providing the care. Plans shall exercise prudent medical case management to ensure that appropriate care is rendered in the appropriate setting. Medical case management may include consideration of whether a particular service or setting is cost-effective when there is a choice among several medically appropriate alternative services or settings.

Exclusions: Custodial care

(15) Skilled Nursing Care: Services prescribed by a plan physician or nurse practitioner and provided in a licensed skilled nursing facility when medically necessary. Skilled nursing on a 24-hour per day basis; bed and board; x-ray and laboratory procedures; respiratory therapy; physical, occupational and speech therapy; medical social services; prescribed drugs and medications; medical supplies; and appliances and equipment ordinarily furnished by the skilled nursing facility. This benefit shall be limited to a maximum of 100 days per benefit year.

Exclusions: Custodial care.

(16) Physical, Occupational, and Speech Therapy: Therapy may be provided in a medical office or other appropriate outpatient setting, hospital, skilled nursing facility or home. Plans may require periodic evaluations as long as therapy, which is medically necessary, is provided.

(17) Acupuncture and Chiropractic: These are optional benefits which plans may offer. If offered, the plan must provide a self referral benefit, and cannot require referral from a primary care or other physician or health professional. For subscribers, coverage is limited to a maximum of 20 visits each per benefit year for acupuncture and chiropractic. Plans may provide a combined chiropractic/ acupuncture benefit with a minimum of 20 visits allowed for both disciplines.

(18) Biofeedback is an optional benefit which health plans may offer.

(19) Blood and Blood Products: Processing, storage, and administration of blood and blood products in inpatient and outpatient settings. Includes the collection and storage of autologous blood when medically indicated.

(20) Health Education: Effective health education services, including information regarding personal health behavior and health care, and recommendations regarding the optimal use of health care services provided by the plan or health care organizations affiliated with the plan.

(21) Hospice: The hospice benefit shall include nursing care, medical social services, home health aide services, physician services, drugs, medical supplies and appliances, counseling and bereavement services. The benefit shall also include physical therapy, occupational therapy, speech therapy, short-term inpatient care, pain control, and symptom management.

The hospice benefit may include, at the option of the health plan, homemaker services, services of volunteers, and short-term inpatient respite care.

The hospice benefit is limited to those individuals who are diagnosed with a terminal illness with a life expectancy of twelve months or less and who elect hospice care for such illness instead of the traditional services covered by the plan.

Individuals who elect hospice care are not entitled to any other benefits under the plan for the terminal illness while the hospice election is in effect. The hospice election may be revoked at any time.

(22) Transplants: Coverage for medically necessary organ transplants and bone marrow transplants which are not experimental or

investigational in nature. Reasonable medical and hospital expenses of a donor or an individual identified as a prospective donor if these expenses are directly related to the transplant for a subscriber.

Charges for testing of relatives for matching bone marrow transplants.

Charges associated with the search and testing of unrelated bone marrow donors through a recognized Donor Registry and charges associated with the procurement of donor organs through a recognized Donor Transplant Bank, if the expenses are directly related to the anticipated transplant of a subscriber.

(23) Reconstructive Surgery: Reconstructive surgery to restore and achieve symmetry and surgery performed to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors or disease to do either of the following:

(A) Improve function

(B) Create a normal appearance to the extent possible Includes reconstructive surgery to restore and achieve symmetry incident to mastectomy.

(24) Participating health plans shall be responsible for identifying subscribers under the age of 21 who have conditions for which they may be eligible to receive services under the California Children's Services (CCS) Program and shall refer these individuals to the local CCS Program for determination of eligibility. If a subscriber is determined by the CCS Program to be eligible for CCS benefits, participating health plans shall provide primary care and services unrelated to the CCS eligible condition and shall ensure coordination of services between plan providers, CCS providers, and the local CCS Program.

(25) Participating health plans shall be responsible for identifying subscriber children who are severely emotionally disturbed and shall refer these individuals to their county mental health department for continued treatment of the condition.

(b) This part shall not be construed to prohibit a plan's ability to impose cost-control mechanisms. Such mechanisms may include but are not limited to requiring prior authorization for benefits or providing benefits in alternative settings or using alternative methods.

(c) (1) The scope of benefits shall include all benefits which are covered under the California Children's Services (CCS) Program (Health and Safety Code Section 123800, et seq.), provided the subscriber meets the medical eligibility requirements of that program, as determined by that program.

(2) When a subscriber under the age of 21 is determined by the CCS Program to be eligible for benefits under that program, a participating health plan shall not be responsible for the provision of, or payment for, the particular services authorized by the CCS Program for the particular subscriber for the treatment of CCS eligible medical condition. All other services provided under the participating health plan shall be available to the subscriber.

(d) (1) The scope of benefits shall include benefits provided by a county mental health department to a subscriber child the department has determined is seriously emotionally disturbed or has a serious mental disorder pursuant to Section 5600.3 of the Welfare and Institutions Code.

(2) When a subscriber child is determined by a county mental health department to be seriously emotionally disturbed or to have a serious mental disorder pursuant to Section 5600.3 of the Welfare and Institutions Code, the participating health plan shall not be responsible for the provision of, or payment for, services provided by the county mental health department. This does not relieve the participating health plan from providing the mental health coverage specified in Section 2699.6700(a)(12).

NOTE: Authority cited: Sections 12693.21 and 12693.755, Insurance Code. Reference: Sections 12693.21, 12693.60, 12693.61, 12693.62 and 12693.755, Insurance Code.

2699.6703. Excluded Health Benefits.

(a) Health benefit plans offered under this program shall exclude all of the following:

(1) Any services or items specified as excluded within Section 2699.6700.

(2) Any benefits in excess of limits specified in Section 2699.6700.

(3) Services, supplies, items, procedures or equipment, which are not medically necessary as determined by the plan, unless otherwise specified in Section 2699.6700.

(4) Any services which are received prior to the subscriber's effective date of coverage.

(5) Those medical, surgical (including implants), or other health care procedures, services, products, drugs, or devices which are either:

(A) Experimental or investigational or which are not recognized in accord with generally accepted medical standards as being safe and effective for use in the treatment in question, or

(B) Outmoded or not efficacious.

(6) Emergency facility services for non-emergency conditions.

(7) Eyeglasses, except for those eyeglasses or contact lenses necessary after cataract surgery which are covered under Subsection 2699.6700(a)(7).

(8) Treatment for infertility is excluded. Diagnosis of infertility for subscribers is not covered unless provided in conjunction with covered gynecological services. Treatments of medical conditions of the reproductive system are not excluded.

(9) Long-term care benefits including long-term skilled nursing care in a licensed facility and respite care are excluded except as a participating health plan shall determine they are less costly, satisfactory alternatives to the basic minimum benefits. This section does not exclude short-term skilled nursing care or hospice benefits as provided pursuant to Subsection 2699.6700 (a)(15) and (a)(21).

(10) Treatment for any bodily injury or sickness arising from or sustained in the course of any occupation or employment for compensation, profit or gain for which benefits are provided or payable under any Worker’s Compensation benefit plan. The participating health plan shall provide the services at the time of need, and the subscriber or applicant shall cooperate to assure that the participating health plan is reimbursed for such benefits.

(11) Services which are eligible for reimbursement by insurance or covered under any other insurance or health care service plan. The participating health plan shall provide the services at the time of

need, and the subscriber or applicant shall cooperate to assure that the participating health plan is reimbursed for such benefits.

(12) Cosmetic surgery that is solely performed to alter or reshape normal structures of the body in order to improve appearance.

NOTE: Authority cited: Sections 12693.21 and 12693.755, Insurance Code. Reference: Sections 12693.21, 12693.60 and 12693.755, Insurance Code.

2699.6705. Share of Cost for Health Benefits.

(a) Every participating health plan shall require copayments for benefits provided to subscribers, except as provided under federal law to subscribers who are American Indians receiving services at an Indian Health Service Facility, subject to the following:

(1) In any benefit year that the applicant has incurred $250 in health benefit copayments for services received by subscribers who live in one household and for whom the applicant applied to the program, the applicant shall be deemed to have met the copayment maximum.

(2) No deductibles shall be charged to subscribers for health benefits.

(3) The following specific copayments shall apply:

(A) Inpatient facility services provided in a licensed hospital, skilled nursing facility, hospice, or mental health facility: No copayment.

(B) Inpatient professional services provided in a licensed hospital, skilled nursing facility, hospice, or mental health facility: No copayment.

(C) Facility services on an outpatient basis for subscribers: No copayment, except for a $5 copayment per visit for Emergency Health Care Services. The emergency health care services copay is waived if the subscriber is hospitalized.

(D) Outpatient professional services: $5 copayment per office or home visit. No copayment for surgery or anesthesia; radiation, chemotherapy, or dialysis treatments.

(E) Outpatient mental health: $5 copayment per visit.

(F) Home health care: No copayment except for $5 per visit for physical, occupational, and speech therapy visits performed in the home.

(G) Alcohol and drug abuse: No copayment for inpatient services. $5 per visit for outpatient services.

(H) Hospice: No copayment for any services provided under this benefit.

(I) Transplants: No copayment for any services provided under this benefit.

(J) Physical, occupational, and speech therapy: No copayment for therapy performed on an inpatient basis. $5 copayment per visit for therapy performed in the home or other outpatient setting.

(K) Biofeedback, acupuncture, and chiropractic visits, when offered at the participating health plan's option: $5 copayment per visit. For subscriber parents, copayment of $5 for each biofeedback visit for mental health.

(L) Diagnostic laboratory services, diagnostic and therapeutic radiological services, and other diagnostic services; durable medical equipment, prosthetics and orthotics; blood and blood products; medical transportation services: No copayment.

(M) Hearing Aids: No copayment.

(N) Prescription Drugs: No copayment for prescription drugs provided in an inpatient setting, or for drugs administered in the doctor's office or in an outpatient facility setting during the subscriber's stay at the facility. $5 per prescription for up to a 30-34 day supply for brand name or generic drugs, including tobacco use cessation drugs. For subscriber children, no copayment for FDA approved contraceptive drugs and devices including Norplant.

For subscriber parents, $5 copayment for 90 day supply of FDA approved oral and injectable contraceptives and contraceptive devices. No refund if the medication is removed. (Represents the copayment for oral contraceptives at $5 copay for each 90-day supply for the approximate number of months the medication will be effective).

Maintenance drugs: $5 copayment per 90-100 day supply either through a participating health plan's participating pharmacies or through its mail order program. Maintenance drugs are drugs that are prescribed for 60 days or longer and are usually prescribed for chronic conditions such as arthritis, heart disease, diabetes, or hypertension.

(4) Preventive services, including services for the detection of asymptomatic diseases, as defined by applicable Department of Managed Health Care regulations. These include:

(A) Periodic health exams; no copayment for subscriber children; $5 copayment per exam for subscriber parents.

(B) A variety of voluntary family planning services; no copayment for subscriber children. For subscriber parents $5 copayment per office visit.

Contraceptive services – no copayment for subscriber children. $5 copayment per visit and $5 copayment per device for subscriber parents.

(C) Prenatal care; no copayment.

(D) Vision and hearing testing; no copayment for subscriber children. For subscriber parents, $5 copayment per visit.

Eye refraction to determine the need for corrective lenses- no copayment for subscriber children. For subscriber parents, optional with $5 copayment per exam and limited to one visit per year.

(E) Immunizations; no copayment for subscriber children. $5 copayment per visit for subscriber parent.

(F) Venereal disease tests; No copayment for subscriber children. $5 copayment for subscriber parents.

(G) Cytology examinations on a reasonable periodic basis; no copayment for subscriber children. For subscriber parents, $5 copayment per exam.

(H) Effective health education services, including information regarding personal health behavior and health care, and recommendations regarding the optimal use of health care

services provided by the participating health plan or health care organizations affiliated with the participating health plan. No copayment for subscriber children.
For subscriber parents, up to $5 copayment for diabetes outpatient self-management training, education, and medical nutrition therapy services. Charge may vary for other education services.

(5) No copayment shall be charged to subscribers under 24 months of age for well baby care, health examinations and other office visits.

(6) No copayments shall apply if the applicant has submitted acceptable documentation as described in Subsection 2699.6600(c)(1)(GG) that the applicant or the subscriber is American Indian or Alaska Native.

(7) Reconstructive Surgery – no copayment

NOTE: Authority cited: Sections 12693.21 and 12693.755, Insurance Code.
Reference: Sections 12693.21, 12693.615 and 12693.755, Insurance Code.

2699.6707. Annual or Lifetime Benefit Maximums.

There shall be no annual or lifetime financial benefit maximums in any of the coverage under the program.

NOTE: Authority cited: Section 12693.21, Insurance Code.
Reference: Sections 12693.21, 12693.60, 12693.615, Insurance Code.

2699.6709. Scope of Dental Benefits for Subscriber Children.

(a) The basic scope of benefits offered by a participating dental plan shall include all of the benefits and services listed in this section, subject to the exclusions listed in Section 2699.6713.

The covered dental benefit is limited to the benefit level for the least costly dentally appropriate alternative. If a more costly, optional alternative is chosen by the applicant, the applicant will be responsible for all charges in excess of the covered dental benefit.

No other dental benefits for subscriber children shall be permitted to be offered by a participating dental plan as part of the program. The basic scope of dental benefits shall be as follows:

(1) Diagnostic and Preventive Benefits

(A) Initial and periodic oral examinations.

(B) Consultations, including specialist consultations.

(C) Roentgenology, limited as follows:

1. Bitewing x-rays in conjunction with periodic examinations are limited to one series of four films in any 6 consecutive month period. Isolated bitewing or periapical films are allowed on an emergency or episodic basis.

2. Full mouth x-rays in conjunction with periodic examinations are limited to once every 24 consecutive months.

3. Panoramic film x-rays are limited to once every 24 consecutive months.

(D) Prophylaxis services, limited as follows: Not to exceed two in a twelve month period.

(E) Topical fluoride treatment.

(F) Dental sealant treatments, limited as follows: Permanent first and second molars only.

(G) Space maintainers, including removable acrylic and fixed band type.

(H) Preventive dental education and oral hygiene instruction.

(2) Restorative Dentistry

(A) Restorations, limited as follows:

1. Amalgam, composite resin, acrylic, synthetic or plastic restorations for treatment of caries. If the tooth can be restored with such materials, any other restoration such as a crown or jacket is considered optional.

2. Composite resin or acrylic restorations in posterior teeth are optional.

3. Micro filled resin restorations which are noncosmetic.

4. Replacement of a restoration is covered only when it is defective, as evidenced by conditions such as recurrent caries or fracture, and replacement is dentally necessary.

(B) Use of pins and pin build-up in conjunction with a restoration.

(C) Sedative base and sedative fillings.

(3) Oral Surgery

(A) Extractions, including surgical extractions

(B) Removal of impacted teeth, limited as follows: Surgical removal of impacted teeth is a covered benefit only when evidence of pathology exists.

(C) Biopsy of oral tissues

(D) Alveolectomies

(E) Excision of cysts and neoplasms

(F) Treatment of palatal torus

(G) Treatment of mandibular torus

(H) Frenectomy

(I) Incision and drainage of abscesses.

(J) Post-operative services including exams, suture removal and treatment of complications.

(K) Root recovery (separate procedure).

(4) Endodontics

(A) Direct pulp capping

(B) Pulpotomy and vital pulpotomy

(C) Apexification filling with calcium hydroxide

(D) Root amputation

(E) Root canal therapy, including culture canal, limited as follows: Retreatment of root canals is a covered benefit only if clinical or radiographic signs of abscess formation are present, and/or the patient is experiencing symptoms. Removal or retreatment of silver points, overfills, underfills, incomplete fills, or broken instruments lodged in a canal, in the absence of pathology, is not a covered benefit.

(F) Apicoectomy

(G) Vitality tests

(5) Periodontics

(A) Emergency treatment, including treatment for periodontal abscess and acute periodontitis.

(B) Periodontal scaling and root planing, and subgingival curettage, limited as follows: Five quadrant treatments in any 12 consecutive months.

(C) Gingivectomy

(D) Osseous or muco-gingival surgery

(6) Crowns and Fixed Bridges

(A) Crowns, including those made of acrylic, acrylic with metal, porcelain, porcelain with metal, full metal, gold onlay or three quarter crown, and stainless steel. Related dowel pins and pin build-up are also included. Crowns are limited as follows:

1. Replacement of each unit is limited to once every 36 consecutive months, except when the crown is no longer functional as determined by the dental plan.

2. Only acrylic crowns and stainless steel crowns are a benefit for children under 12 years of age. If other types of crowns are chosen as an optional benefit for children under 12 years of age, the covered dental benefit level will be that of an acrylic crown.

3. Crowns will be covered only if there is not enough retentive quality left in the tooth to hold a filling. For example, if the buccal or lingual walls are either fractured or decayed to the extent that they will not hold a filling.

4. Veneers posterior to the second bicuspid are considered optional. An allowance will be made for a cast full crown.

(B) Fixed bridges, which are cast, porcelain baked with metal, or plastic processed to gold, are limited as follows:

1. Fixed bridges will be used only when a partial cannot satisfactorily restore the case. If fixed bridges are used when a partial could satisfactorily restore the case, it is considered optional treatment.

2. A fixed bridge is covered when it is necessary to replace a missing permanent anterior tooth in a person 16 years of age or older and the patient's oral health and general dental condition permits. Under the age of 16, it is considered optional dental treatment. If performed on a subscriber under the age of 16, the applicant must pay the difference in cost between the fixed bridge and a space maintainer.

3. Fixed bridges used to replace missing posterior teeth are considered optional when the abutment teeth are dentally sound and would be crowned only for the purpose of supporting a pontic.

4. Fixed bridges are optional when provided in connection with a partial denture on the same arch.

5. Replacement of an existing fixed bridge is covered only when it cannot be made satisfactory by repair.

(C) The program allows up to five units of crown or bridgework per arch. Upon the sixth unit, the treatment is considered full mouth reconstruction which is optional treatment.

(D) Recementation of crowns, bridges, inlays and onlays.

(E) Cast post and core, including cast retention under crowns.

(F) Repair or replacement of crowns, abutments or pontics.

(7) Removable Prosthetics

(A) Dentures, full maxillary, full mandibular, partial upper, partial lower, teeth, clasps and stress breakers, limited as follows:

1. Partial dentures are not to be replaced within 36 consecutive months, unless:

a. it is necessary due to natural tooth loss where the addition or replacement of teeth to the existing partial is not feasible, or

b. the denture is unsatisfactory and cannot be made satisfactory.

2. The covered dental benefit for partial dentures will be limited to the charges for a cast chrome or acrylic denture if this would satisfactorily restore an arch. If a more elaborate or precision appliance is chosen by the patient and the dentist, and is not necessary to satisfactorily restore an arch, the patient will be responsible for all additional charges.

3. A removable partial denture is considered an adequate restoration of a case when teeth are missing on both sides of the dental arch. Other treatments of such cases are considered optional.

4. Full upper and/or lower dentures are not to be replaced within 36 consecutive months unless the existing denture is unsatisfactory and cannot be made satisfactory by reline or repair.

5. The covered dental benefit for complete dentures will be limited to the benefit level for a standard procedure. If a more personalized or specialized treatment is chosen by the patient and the dentist, the applicant will be responsible for all additional charges.

(B) Office or laboratory relines or rebases, limited as follows: One per arch in any 12 consecutive months.

(C) Denture repair.

(D) Denture adjustment.

(E) Tissue conditioning, limited to two per denture.

(F) Denture duplication.

(G) Implants are considered an optional benefit.

(H) Stayplates, limited as follows: Stayplates are a benefit only when used as anterior space maintainers for children.

(8) Orthodontic Treatment, limited as follows: If the subscriber child meets the eligibility requirements for medically necessary orthodontia coverage under the California Children's Services program, benefits shall be provided and determined by the California Children's Services program.

(9) Other Dental Benefits

(A) Local anesthetics.

(B) Oral sedatives when dispensed in a dental office by a practitioner acting within the scope of their licensure.

(C) Nitrous oxide when dispensed in a dental office by a practitioner acting within the scope of their licensure.

(D) Emergency treatment, palliative treatment.

(E) Coordination of benefits with subscriber's health plan in the event hospitalization or outpatient surgery setting is medically appropriate for dental services.

(10) This part shall not be construed to prohibit a dental plan's ability to impose cost control mechanisms. Such mechanisms may include but are not limited to requiring prior authorization for benefits or providing alternative treatments or services.

(11) Participating dental plans shall be responsible for identifying subscribers under the age of 21 who have conditions for which they may be eligible to receive services under the California Children's Services (CCS) Program and shall refer these

individuals to the local CCS Program for determination of eligibility. If a subscriber is determined by the CCS Program to be eligible for CCS benefits, participating dental plans shall provide primary care and services unrelated to the CCS eligible condition and shall ensure coordination of services between plan providers, CCS providers, and the local CCS program.

(b) (1) The scope of dental benefits shall also include all dental benefits which are covered under the California Children's Services program (Health and Safety Code Section 123800 et seq.), provided the subscriber meets the medical eligibility requirements of that program, as determined by that program.

(2) When a subscriber under the age of 21 is determined by the California Children's Services Program (Health and Safety Code Section 123800 et seq.) to be eligible for benefits under that program, a participating dental plan shall not be responsible for the provision of, or payment for, the particular services authorized by the California Children's Services Program for the particular subscriber for the treatment of a California Children's Services Program eligible medical condition. All other services provided under the participating dental plan shall be available to the subscriber.

NOTE: Authority cited: Sections 12693.21 and 12693.755, Insurance Code. Reference: Sections 12693.21, 12693.63, 12693.64 and 12693.755, Insurance Code.

2699.6711. Scope of Dental Benefits for Subscriber Parents.

(a) The basic scope of benefits offered by a participating dental plan shall include all of the benefits and services listed in this section, subject to certain exclusions as listed.

The covered dental benefit is limited to the benefit level for the least costly dentally appropriate alternative. If a more costly, optional alternative is chosen by the applicant, the applicant will be responsible for all charges in excess of the covered dental benefits.

No other dental benefits shall be permitted to be offered by a participating dental plan as part of the program. The basic scope of dental benefits shall be as follows:

(1) Diagnosis and Preventive Benefits

(A) Initial and periodic oral examinations – oral examinations are benefits only twice in a benefit year.

(B) Consultations, including specialist consultations

(C) Roentgenology, limited as follows:

1. Bitewing x-rays in conjunction with periodic examinations are limited to one series of four films in a benefit year.

2. Full mouth x-rays in conjunction with periodic examinations are limited to once in a three-year period unless special need is shown.

3. Panoramic film x-rays are limited to once in a three year period.

(D) Prophylaxis services, not to exceed two in a twelve month period.

A third cleaning will be provided as a benefit for high-risk patients in the following categories:

1. Women who are pregnant

2. Subscribers undergoing cancer chemotherapy

3. Subscribers with compromising systemic diseases such as diabetes as determined to be medically necessary for appropriate dental care by the provider and approved by the plan.

(E) Space maintainers, including removable acrylic and fixed band type.

(F) Preventive dental education and oral hygiene instructions

(2) Restorative Dentistry – amalgam, synthetic, plastic or resin restorations (fillings) for treatment of cavities (decay)

(A) Restorations, limited as follows:

1. Amalgam, composite resin, acrylic, synthetic or plastic restorations for treatment of caries. If the tooth can be restored with such materials, any other restoration such as a crown or jacket is considered optional.

2. Composite resin or acrylic restorations in posterior teeth are optional.

3. Micro filled resin restorations which are noncosmetic

4. Replacement of a restoration is covered only when it is defective, as evidenced by conditions such as recurrent caries or fracture, and replacement is dentally necessary.

(B) Use of pins and pin build-up in conjunction with a restoration.

(C) Sedative base and sedative fillings.

(3) Oral Surgery-extractions and certain other surgical procedures, including pre-and post-operative care.

(A) Extractions, including surgical extractions.

(B) Removal of impacted teeth. Surgical removal of impacted teeth is a covered benefit only when evidence of pathology exists.

(C) Biopsy of oral tissues

(D) Alveolectomies

(E) Excision of cysts and neoplasms

(F) Treatment of palatal torus

(G) Treatment of mandibular torus

(H) Frenectomy

(I) Incision and drainage of abscesses

(J) Post-operative services including exams, suture removal and treatment of complications.

(K) Root recovery (separate procedure)

(4) Endodontics – treatment of tooth pulp

(A) Direct pulp capping

(B) Pulpotomy and vital pulpotomy

(C) Apexification filling with calcium hydroxide

(D) Root amputation

(E) Root canal therapy, including culture canal, limited as follows.
Retreatment of root canals is a covered benefit only if clinical or radiographic signs of abscess formation are present, and/or the patient is experiencing symptoms. Removal or retreatment of silver points, overfills, underfills, incomplete fills, or broken instruments lodged in a canal, in the absence of pathology is not a covered benefit.

(F) Apicoectomy

(G) Vitality tests

(5) Periodontics – treatment of gums and bones that support the teeth

(A) Emergency treatment, including treatment for periodontal abscess and acute periodontitis.

(B) Periodontal scaling and root planing, and subgingival curettage, limited as follows: Five quadrant treatments in any 12 consecutive months.

(C) Gingevectomy

(D) Osseous or muco-gingival surgery Periodontal procedures which include cleanings are subject to the same limitations as other cleanings i.e., cleaning of any kind are benefits no more than twice in a benefit year except for high-risk patients as described in (a)(1)(D)1.

(6) Crown, Jackets, Cast and Fixed Bridges – crowns, jackets and cast restorations are benefits only if they are provided to treat cavities that cannot be restored with amalgam, synthetic plastic or resin fillings.

(A) Crowns, including those made of acrylic, acrylic with metal, porcelain, porcelain with metal, full metal, gold

onlay or three-quarter crown, and stainless steel. Related dowel pins and pin build-up are also included. Crowns are limited as follows:

1. Replacement of each unit is limited to once every five years.

2. Crowns will be covered only if there is not enough retentive quality left in the tooth to hold a filling. For example, if the buccal or lingual walls are either fractured or decayed to the extent that they will not hold a filling.

3. Veneers posterior to the second biscupid are considered optional. An allowance will be made for a cast full crown.

(B) Fixed bridges, which are cast, porcelain baked with metal, or plastic processed to gold, are limited as follows:

1. Fixed bridges will be used only when a partial cannot satisfactorily restore the case. If fixed bridges are used when a partial could satisfactorily restore the case, it is considered optional treatment.

2. A fixed bridge is covered when it is necessary to replace a missing permanent anterior tooth and the patient's oral health and general dental condition permits.

3. Fixed bridges used to replace missing posterior teeth are considered optional when the abutment teeth are dentally sound and would be crowned only for the purpose of supporting a pontic.

4. Fixed bridges are optional when provided in connection with a partial denture on the same arch.

5. Replacement of an existing fixed bridge is covered only when it cannot be made satisfactory by repair.

(C) The program allows up to five units of crown or bridgework per arch. Upon the sixth unit, the treatment is considered full mouth reconstruction which is an optional treatment.

(D) Recementation of crowns, bridges, inlays and onlays.

(E) Cast post and core, including cast retention under crowns.

(F) Repair or replacement of crowns, abutments or pontics.

(7) Removable Prosthetics

(A) Dentures, full maxillary, full mandibular, partial upper, partial lower, teeth, clasps and stress breakers, limited as follows:

1. Partial dentures are not to be replaced within five years unless:

a. it is necessary due to natural tooth loss where the addition or replacement of teeth to the existing partial is not feasible, there has been such an extensive loss of remaining teeth, or a change in supporting tissues, or

b. the denture is unsatisfactory and cannot be made satisfactory.

2. The covered dental benefit for partial dentures will be limited to the charges for a cast chrome or acrylic denture if this would satisfactorily restore an arch. If a more elaborate or precision appliance is chosen by the patient and the dentist, and is not necessary to satisfactorily restore an arch, the patient will be responsible for all additional charges.

3. A removable partial denture is considered an adequate restoration of a case when teeth are missing on both sides of the dental arch. Other treatments of such cases are considered optional.

4. Full upper and/or lower dentures are not to be replaced within five years unless the existing denture is unsatisfactory and cannot be made satisfactory by reline or repair, the plan determines that there has been such an extensive loss of remaining teeth, or a change in supporting tissue that the existing appliance cannot be made satisfactory.

5. The covered dental benefit for complete dentures will be limited to the benefit level for a standard procedure. The plan will pay the applicable percentage of the dentist's fee for a standard partial or complete denture up to a maximum fee allowance (or established UCR fee). If a more personalized or specialized treatment is chosen by the patient and the dentist, the applicant will be responsible for all additional charges.

(B) Office or laboratory relines or rebases, limited to one per arch in any 12 consecutive months.

(C) Denture Repair

(D) Denture adjustment

(E) Tissue conditioning, limited to two per denture

(F) Denture duplication

(G) Implants (appliances inserted into bone or soft tissue in the jaw usually to anchor a denture) are covered.

(H) Stayplates – provided as a benefit only when used to replace extracted anterior teeth for adults during a healing period.

(8) Other Dental Benefits

(A) Local anesthetics

(B) Oral sedatives when dispensed in a dental office by a practitioner acting within the scope of their licensure.

(C) Nitrous oxide when dispensed in a dental office by a practitioner acting within the scope of their licensure.

(D) Emergency treatment, palliative treatment.

(E) Coordination of benefits with subscriber's health plan in the event hospitalization or outpatient surgery setting is medically appropriate for dental services.

(9) This part shall not be construed to prohibit a dental plan's ability to impose cost control mechanisms. Such mechanisms may include but are not limited to requiring prior authorization for benefits or providing alternative treatments or services.

(10) Participating dental plans shall be responsible for identifying subscribers under the age of 21 who have conditions for which they may be eligible to receive services under the California Children's Services (CCS) Program and shall refer these individuals to the local CCS Program for determination of eligibility. If a subscriber is determined by the CCS Program to be eligible for CCS benefits, participating dental plans shall provide primary care and services unrelated to the CCS eligible condition and shall ensure coordination of services between plan providers, CCS providers, and the local CCS program.

(b) (1) The scope of dental benefits shall also include all dental benefits which are covered under the California Children's Services program (Health and Safety Code Section 123800 et seq.), provided the subscriber meets the medical eligibility requirements of that program, as determined by that program.

(2) When a subscriber under the age of 21 is determined by the California Children's Services Program (Health and Safety Code Section 123800 et seq.) to be eligible for benefits under that program, a participating dental plan shall not be responsible for the provision of, or payment for, the particular services authorized by the California Children's Services Program for the particular subscriber for the treatment of a California Children's Services Program eligible medical condition. All other services provided under the participating dental plan shall be available to the subscriber.

NOTE: Authority cited: Sections 12693.21 and 12693.755, Insurance Code.
Reference: Sections 12693.21, 12693.63 and 12693.755, Insurance Code

2699.6713. Excluded Dental Benefits for All Subscribers.

(a) A dental benefits plan offered under this program shall exclude:

(1) Services which, in the opinion of the attending dentist, are not necessary to the subscriber's dental health.

(2) Procedures, appliances, or restorations to correct congenital or developmental malformations are not covered benefits unless specifically listed in Section 2699.6709 and 2699.6711.

(3) Cosmetic dental care.

(4) General anesthesia or intravenous/conscious sedation unless specifically listed as a benefit or is given by a dentist for covered oral surgery.

(5) Experimental procedures.

(6) Dental conditions arising out of and due to a subscribers employment for which Worker's Compensation or an Employer's Liability Law is payable. The participating dental plan shall provide the services at the time of need, and the subscriber or applicant shall cooperate to assure that the participating dental plan is reimbursed for such benefits.

(7) Services which were provided without cost to the subscriber by State government or an agency thereof, or any municipality, county or other subdivisions.

(8) Hospital charges of any kind.

(9) Major surgery for fractures and dislocations.

(10) Loss or theft of dentures or bridgework.

(11) Dental expenses incurred in connection with any dental procedures started after termination of coverage or prior to the date the subscriber became eligible for such services.

(12) Any service that is not specifically listed as a covered benefit.

(13) Malignancies.

(14) Dispensing of drugs not normally supplied in a dental office.

(15) Additional treatment costs incurred because a dental procedure is unable to be performed in the dentist's office due to the general health and physical limitations of the subscriber.

(16) The cost of precious metals used in any form of dental benefits.

(17) The removal of implants.

(18) Services of a pedodontist/pediatric dentist for subscriber children except when a subscriber child is unable to be treated by his or her

panel provider, or treatment by a pedodontist/pediatric dentist is medically necessary, or his or her panel provider is a pedodontist/pediatric dentist.

(19) Services which are eligible for reimbursement by insurance or covered under any other insurance, health care service plan, or dental plan. The participating dental plan shall provide the services at the time of need, and the subscriber or applicant shall cooperate to assure that the participating dental plan is reimbursed for such benefits.

NOTE: Authority cited: Sections 12693.21 and 12693.755, Insurance Code. Reference: Sections 12693.21, 12693.63 and 12693.755, Insurance Code.

2699.6715. Share of Cost for Dental Benefits for Subscriber Children.

(a) Every participating dental health plan shall require copayments for the dental benefits listed in Subsection 2699.6709 (a) of these regulations provided to subscribers subject to the following:

(1) No copayments shall be charged for benefits listed under Subsection 2699.6709(a)(1), “Diagnostic and Preventive Benefits.”

(2) No copayments shall be charged for benefits listed under Subsection 2699.6709(a)(2), “Restorative Dentistry.”

(3) No copayments shall be charged for benefits listed under Subsection 2699.6709(a)(3), “Oral Surgery”, with the following exceptions:

(A) Removal of impacted teeth is subject to a copayment per tooth as follows:

1. Soft tissue impaction -- No copayment.

2. Bony impaction -- $5 copayment per tooth.

(B) Root recovery -- $5 per root.

(4) No copayments shall be charged for benefits listed under Subsection 2699.6709(a)(4), “Endodontics”, with the following exceptions:

(A) Root canal --therapy $5 per canal.

(B) An apicoectomy performed in conjunction with root canal therapy is subject to a copayment of $5 per canal. When performed as a separate procedure, an apicoectomy is subject to a copayment of $5 per canal.

(5) No copayments shall be charged for benefits listed under Subsection 2699.6709(a)(5), “Periodontics”, with the following exceptions:

(A) Osseous or muco-gingival surgery -- $5 per quadrant.

(B) Gingivectomy -- no copayment.

(6) No copayments shall be charged for benefits listed under Subsection 2699.6709(a)(6), “Crowns and Fixed Bridges” with the following exceptions:

(A) Porcelain crowns; porcelain fused to metal crowns; full metal crowns; and gold onlays or 3/4 crowns; are each subject to a copayment of $5.

(B) Pontics are each subject to a copayment of $5.

(7) No copayments shall be charged for benefits listed under Subsection 2699.6709(a)(7), “Removable Prosthetics”, with the following exceptions:

(A) Dentures are subject to copayments as follows:

1. Complete maxillary denture --$5.

2. Complete mandibular denture -- $5.

3. Partial acrylic upper or lower denture with clasps-- $5.

4. Partial upper or lower denture with chrome cobalt alloy lingual or palatal bar, clasps and acrylic saddles -$5.

5. Removable unilateral partial denture -- $5.

(B) Reline for an upper, lower or partial denture is subject to a copayment per unit as follows:

1. Office reline -- No copayment.

2. Laboratory reline --$5.

(C) Denture duplication-- $5.

(8) No copayments shall be charged for benefits listed under Subsection 2699.6709(c)(8), “Orthodontia.”

(9) No copayments shall be charged for benefits listed under Subsection 2699.6709(a)(9), “Other”.

(10) The copayment for any precious (noble) metals used in any crown or bridge will be the full cost of the actual precious metal used.

(11) Notwithstanding any other provision in this section, an alternative copayment shall apply under the following circumstances: For children under six years of age, who are unable to be treated by their panel provider, and who have been referred to a pedodontist/pediatric dentist, the copayment is $5.

(b) A fee of $5 shall be charged for failure to cancel an appointment without 24 hours prior notification.

(c) No deductibles shall be charged to subscriber children for dental benefits.

(d) No copayments or fees shall apply if the applicant has submitted acceptable documentation as described in Subsection 2699.6600(c)(1)(FF) that the applicant or subscriber is American Indian or Alaska Native.

NOTE: Authority cited: Section 12693.21, Insurance Code.
Reference: Sections 12693.21, 12693.63, Insurance Code.

2699.6717. Share of Cost for Dental Benefits for Subscriber Parents.

(a) Every participating dental plan shall require copayments for the dental benefits provided to subscriber parents subject to the following:

(1) No copayments shall be charged for benefits listed under Subsection 2699.6711(a)(1), “Diagnostic and Preventive.”

(2) No copayments shall be charged for benefits listed under Subsection 2699.6711(a)(2), “Restorative Dentistry”, with the following exceptions:

(A) Micro filled resin restorations (non-cosmetic, acid etched, bonded, light cured):

1. $40 per surface

2. $65 for two or more surfaces

(3) No copayments shall be charged for benefits listed under subsection 2699.6711(a)(3), “Oral Surgery”, with the following exceptions:

(A) Removal of impacted teeth is subject to a copayment per tooth as follows:

1. Partially bony impaction -- $15 copayment.

2. Complete bony impaction -- $15 copayment.

(B) Root recovery as a separate procedure -- $5 per root.

(4) No copayments shall be charged for benefits listed under Subsection 2699.6711(a)(4), “Endodontics” with the following exceptions:

(A) Root canal therapy (excluding restoration) is subject to copayments as follows:

1. 1 canal - $20

2. 2 canals - $40

3. 3 canals - $60

4. 4 canals - $80

(B) An apicoectomy performed in conjunction with filling or root canal therapy at the same time is subject to a copayment of $60 per canal. When performed as a separate procedure, an apicoectomy is subject to a copayment of $50 per canal.

(5) No copayments shall be charged for benefits listed under subsection 2699.6711(a)(5), “Periodontics”, with the following exceptions:

(A) Osseous or muco-gingival surgery is subject to a copayment of $150 per quadrant (includes post surgical visits).

(B) Gingivectomy is subject to a $5 copayment per tooth (fewer than six teeth).

(6) No copayments shall be charged for benefits listed under subsection 2699.6711(a)(6), “Crowns and Bridges” (per unit), with the following exceptions:

(A) Porcelain crowns; porcelain fused to metal crowns (excluding molars) full crowns, or 3/4 crowns; are each subject to a copayment of $50. Cast post and core are subject to $40 per unit copayment, and bonded Maryland Bridge is subject to $50 copayment per unit.

(B) Pontics are each subject to a copayment of $50.

(7) “Removable Prosthetics” as listed under Subsection 2699.6711(a)(7) are subject to the following copayments:

(A) Dentures are subject to copayments as follows:

1. Complete upper denture (3 adjustments within 60 days) - $65.

2. Complete lower denture (3 adjustments within 60 days) - $65.

3. Partial acrylic upper or lower denture with clasps - $5.

4. Partial acrylic upper or lower denture with 2 chrome cobalt allow clasps is subject to a base fee of $65.

5. Partial lower or upper denture with chrome cobalt allow, lingual or palatal bar, clasps and acrylic saddles - $65 base fee (included two clasps).

6. Removable unilateral partial denture - $50.

7. Stayplate (maximum two teeth included) - $60.

(B) Reline for an upper, lower or partial denture is subject to a copayment per unit as follows:

1. Office reline – No copayment.

2. Laboratory reline - $15 copayment.

(C) Denture duplication -- $20 copayment.

(D) Denture Repairs

1. Adding teeth to partial denture to replace natural tooth:

First tooth - $10 copayment.

Each additional tooth - $5 copayment.

2. Broken partial denture (no teeth involved)

Replacement broken clasp - $5 copayment.

3. Add clasp with rest - $5 copayment.

(8) Other Services

After hour visit - $35 copayment.

Broken appointment - $5 copayment.

(9) Implants – If implants are utilized, the plan will apply the cost of a standard full or partial denture towards the cost of implants and appliances constructed thereon, and if performed, subscriber parent must pay the difference plus any applicable copayment. Surgical removal of implants is not covered.

(b) No deductibles shall be charged to subscriber parents for dental benefits.

(c) No copayments or fees shall apply if the applicant has submitted acceptable documentation as described in Subsection 2699.6600(c)(1)(GG)that the applicant or subscriber is American Indian or Alaska Native.

(d) Note: Any procedure not listed in the EOC is available on a fee-for service basis.

NOTE: Authority cited: Sections 12693.21 and 12693.755, Insurance Code. Reference: Sections 12693.21, 12693.63 and 12693.755, Insurance Code.

2699.6719 Waiting Periods for Receipt of Specified Benefits.

Participating dental plans may not subject enrollees to waiting periods for receipt of specified benefits.

NOTE: Authority cited: Section 12693.21, Insurance Code.
Reference: Sections 12693.21, 12693.63, Insurance Code.

2699.6721. Scope of Vision Benefits.

(a) The basic scope of benefits offered by a participating vision plan as a vision benefit plan shall include all of the benefits and services listed in this section, subject to the exclusions listed in Section 2699.6723. No other vision benefits shall be permitted to be offered by a participating vision plan as part of the program. The basic scope of vision benefits shall be as follows:

(1) Examinations: Each subscriber shall be entitled to a comprehensive vision examination, including a complete analysis of the eyes and related structures, as appropriate, to determine the presence of vision problems or other abnormalities as follows:

(A) Case history: Review of subscriber's main reason for the visit, past history, medications, general health, ocular symptoms, and family history.

(B) Evaluation of the health status of the visual system; including:

1. external and internal examination, including direct and/or indirect ophthalmoscopy;

2. assessment of neurological integrity, including that of pupillary reflexes and extraocular muscles;

3. biomicroscopy of the anterior segment of the eye, including observation of the cornea, lens, iris, conjunctiva, lids and lashes;

4. screening of gross visual fields; and

5. pressure testing through tonometry.

(C) Evaluation of refractive status, including:

1. evaluation for visual acuity;

2. evaluation of subjective, refractive, and accommodative function; and

3. objective testing of a patient's prescription through retinoscopy.

(D) Binocular function test.

(E) Diagnosis and treatment plan, if needed.

(F) Examinations are limited to once each twelve month period, which begins with the date of the last exam.

(2) When the vision examination indicates that corrective lenses are necessary, each subscriber is entitled to necessary frames and lenses, including coverage for single vision, bifocal, trifocal, and lenticular lenses as appropriate.

Frames and lenses are limited to once each twelve month period, which begins with the date of the last exam.

(3) Contact lenses shall be covered as follows:

(A) Necessary contact lenses shall be covered in full upon prior authorization from the vision plan, for certain conditions. These conditions may include the following:

1. following cataract surgery;
2. to correct extreme visual acuity problems that cannot be corrected with spectacle lenses;

3. certain conditions of Anisometropia; and

4. keratoconus.

(B) Elective contact lenses may be chosen instead of corrective lenses and a frame at a maximum benefit allowance of $110, which includes examinations, fittings and lenses.

(C) Contact lenses are limited to once each twelve month period, which begins with the date of the last exam.

(4) A low vision benefit shall be provided to subscribers who have severe visual problems that are not correctable with regular lenses. This benefit requires prior approval from the participating vision plan. With this prior approval, supplementary testing and

supplemental care, including low vision therapy as visually necessary or appropriate, shall be provided.

For subscriber parents, the covered person is required to pay a $5 copayment for any approved Low Vision services.

(5) Participating vision plans shall be responsible for identifying subscribers under the age of 21 who have conditions for which they may be eligible to receive services under the California Children's Services (CCS) Program and shall refer these individuals to the local CCS program for determination of eligibility. If a subscriber is determined by the CCS Program to be eligible for CCS benefits, participating vision plans shall provide services unrelated to the CCS eligible condition and shall ensure coordination of services between plan providers, CCS providers, and the local CCS program.

(b) (1) The scope of vision benefits shall also include all vision benefits which are covered under the California Children's Services Program (Health and Safety Code Section 123800 et seq.), provided the subscriber meets the medical eligibility requirements of that program, as determined by that program.

(2) When a subscriber under the age of 21 is determined by the California Children's Services Program to be eligible for vision benefits under that program, a participating vision plan shall not be responsible for the provision of, or payment for, the particular services authorized by the California Children's Services Program for the particular subscriber for the treatment of a California Children's Services Program eligible medical condition. All other services provided under the participating vision plan shall be available to the subscriber.

NOTE: Authority cited: Sections 12693.21 and 12693.755, Insurance Code. Reference: Sections 12693.21, 12693.65, 12693.66 and 12693.755, Insurance Code.

2699.6723. Excluded Vision Benefits.

(a) A vision benefits plan offered under this program shall exclude:

(1) Benefits which are neither necessary nor appropriate.

(2) Benefits which are not obtained in compliance with the rules and policies of the subscriber's vision plan.

(3) Vision training.

(4) Aniseikonic lenses.

(5) Plano lenses.

(6) Two pairs of glasses in lieu of bifocals, unless medically necessary and with the prior authorization of the vision plan.

(7) Replacement or repair of lost or broken lenses or frames and lenses or frames lost or broken prior to being eligible for services.

(8) Medical or surgical treatment of the eyes.

(9) Services or materials for which the subscriber is covered under a Worker's Compensation policy. The participating vision plan shall provide the services at the time of need, and the subscriber or applicant shall cooperate to assure that the participating vision plan is reimbursed for such benefits.

(10) Eye examinations required as a condition of employment.

(11) Services or materials provided by any other group benefit providing for vision care.

NOTE: Authority cited: Sections 12693.21 and 12693.755, Insurance Code. Reference: Sections 12693.21, 12693.65 and 12693.755, Insurance Code.

2699.6725. Share of Cost for Vision Benefits.

(a) A participating vision plan shall require copayments for benefits provided to subscribers utilizing the services of the vision plan's panel of approved providers subject to the following:

(1) Examinations: $5 copayment per examination.

(2) Frames and lenses: $5 copayment, for frames with lenses, frames or lenses.

A wholesale frame allowance of $30 will be provided by the vision plan. If a subscriber chooses a frame with a wholesale value above $30, the provider will bill the subscriber the difference between the standard retail value of $75 for a $30 wholesale frame and the retail cost of the frame the subscriber has selected.

The following options are considered cosmetic and any costs associated with the selection of these options will be the financial responsibility of the applicant.

(A) Blended lenses (bifocals which do not have a visible dividing line);

(B) Contact lenses except as specified in Section 2699.6721(a)(3);

(C) Oversized lenses (larger than standard lens blank to accommodate prescriptions);

(D) Progressive multifocal lenses;

(E) Coated or laminated lenses;

(F) UV protected lenses.

(G) Other optional cosmetic processes.

(3) Necessary contact lenses, as defined in Subsection 2699.6721(a)(3): no copayment.

(4) Elective contact lenses: an allowance of $110 will be provided by the vision plan toward the cost of an examination, contact lens evaluation, fitting costs and materials. This allowance will be in lieu of all benefits including examination and material costs. The subscriber is responsible for any costs exceeding this allowance.

(5) Low vision benefits:

(A) Supplementary testing: No copayment; and

(B) Supplemental care: Copayment is $5.

(b) Services from providers not included in the vision plan's panel of approved providers:

When a subscriber obtains services from a provider not included in the vision plan's panel of approved providers, the applicant will be responsible for paying the provider for all services and materials received at the time of their appointment. The participating vision plan will reimburse the applicant within fourteen (14) calendar days after receipt of the paid itemized bill or statement, according to the schedule of allowances as follows:

(1) Professional fees:

(A) Vision exams, up to $35.00

(2) Materials:

(A) Each single vision lens, up to $12.50

(B) Each bifocal lens, up to $20.00

(C) Each trifocal lens, up to $25.00

(D) Each lenticular lens, up to $50.00

(E) Frame, up to $40.00

(F) Tint allowance, up to $5.00

(G) Each pair of necessary contact lenses, up to $250.00

(H) Each pair of elective contact lenses, up to $110.00. Determination of whether contact lenses are necessary or elective when obtained from providers not included in the vision plan's panel of approved providers will be the responsibility of the vision plan. Reimbursement for elective contact lenses is in lieu of all benefits, including examination and materials.

(3) Low vision benefits: Low vision benefits obtained from a provider not included in the vision plan's panel of approved providers will be reimbursed in accordance with what the participating vision plan would pay a provider included in the vision plan's panel of approved providers for this benefit.

(c) No deductibles shall be charged to subscribers for vision benefits.

(d) For subscriber parents who receive vision services from one of the participating member doctors, covered services as described are provided with no additional out-of-pocket costs after an applicable copayment. Additional services selected for cosmetic purposes are the financial responsibility of the patient.

(e) No copayments shall apply if the applicant has submitted acceptable documentation as described in Section 2699.6600(c)(1)(~~FF~~GG) that the applicant or the subscriber is American Indian or Alaska Native. However,

there is no limitation on the payments required under Subsection (b) above.

NOTE: Authority cited: Sections 12693.21 and 12693.755, Insurance Code. Reference: Sections 12693.21, 12693.65 and 12693.755, Insurance Code.

ARTICLE 4. RISK CATEGORIES AND FAMILY CONTRIBUTIONS

2699.6800. Risk Categories Dental and Vision.

(a) Subscriber child rates are as follows:

(1) Dental and vision benefits plan rates shall be based exclusively on one risk category: geographic region of the subscriber's residence. The six geographic regions for subscribers residing within the State of California shall be as follows unless they are altered pursuant to (2) below:

(A) Area 1 shall include the counties of Alpine, Amador, Butte, Calaveras, Colusa, Del Norte, El Dorado, Glenn, Humboldt, Inyo, Kings, Lake, Lassen, Mendocino, Modoc, Mono, Monterey, Nevada, Placer, Plumas, San Benito, Shasta, Sierra, Siskiyou, Sutter, Tehama, Trinity, Tulare, Tuolumne, Yuba, and Yolo.

(B) Area 2 shall include the counties of Fresno, Imperial, Kern, Madera, Mariposa, Merced, Napa, Sacramento, San Joaquin, San Luis Obispo, Santa Cruz, Solano, Sonoma, and Stanislaus.

(C) Area 3 shall include the counties of Alameda, Contra Costa, Marin, San Francisco, San Mateo, and Santa Clara.

(D) Area 4 shall include the counties of Orange, Santa Barbara, and Ventura.

(E) Area 5 shall include the county of Los Angeles.

(F) Area 6 shall include the counties of Riverside, San Bernardino, and San Diego.

(2) The Board may allow one or more dental and vision plans to subdivide one or more geographic regions. The Board shall determine which region or regions may be subdivided and the number of subregions into which a region will be divided. No subregion shall be smaller than one county. Plans rates may differ between subregions.

(3) Dental and Vision plan rates shall be paid on a per capita basis and the per capita rate shall not be differentiated on the basis of age or number of subscribers covered by one family contribution.

(b) Subscriber parent rates are as follows:

(1) Dental and vision benefits plan rates shall be based exclusively on one risk category: geographic region of the subscriber's residence. The six geographic regions for subscribers residing within the State of California shall be as follows unless they are altered pursuant to (2) below:

(A) Area 1 shall include the counties of Alpine, Amador, Butte, Calaveras, Colusa, Del Norte, El Dorado, Glenn, Humboldt, Inyo, Kings, Lake, Lassen, Mendocino, Modoc, Mono, Monterey, Nevada, Placer, Plumas, San Benito, Shasta, Sierra, Siskiyou, Sutter, Tehama, Trinity, Tulare, Tuolumne, Yuba, and Yolo.

(B) Area 2 shall include the counties of Fresno, Imperial, Kern, Madera, Mariposa, Merced, Napa, Sacramento, San Joaquin, San Luis Obispo, Santa Cruz, Solano, Sonoma, and Stanislaus.

(C) Area 3 shall include the counties of Alameda, Contra Costa, Marin, San Francisco, San Mateo, and Santa Clara.

(D) Area 4 shall include the counties of Orange, Santa Barbara, and Ventura.

(E) Area 5 shall include the county of Los Angeles.

(F) Area 6 shall include the counties of Riverside, San Bernardino, and San Diego.

(2) The Board may allow one or more dental and vision plans to subdivide one or more geographic regions. The Board shall determine which region or regions may be subdivided and the number of subregions into which a region will be divided. No subregion shall be smaller than one county. Plans rates may differ between subregions.

(3) Dental and Vision plan rates shall be paid on a per capita basis and the per capita rate shall not be differentiated on the basis of age or number of subscribers covered by one family contribution.

NOTE: Authority cited: Sections 12693.21 and 12693.755, Insurance Code.
Reference: Sections 12693.21, 12693.34, 12693.615 and 12693.755, Insurance Code.

2699.6801. Risk Categories Health.

(a) Subscriber child rates are as follows:

(1) With the exception of rates applicable to AIM infants in the first two calendar months of life, health benefit plan rates shall be based on two risk categories; geographic region of the subscriber's residence and the age of the subscriber. Health plan benefit rates for subscribers entering the program as AIM infants shall initially be determined in accordance with subsection (c).

(2) The age categories for subscriber children shall be as follows:

(A) The first age category is subscribers under the age of one.

(B) The second age category is subscribers of the age of one and over.

(3) The six geographic regions for subscribers residing within the State of California shall be as follows unless they are altered pursuant to (4) below:

(A) Area 1 shall include the counties of Alpine, Amador, Butte, Calaveras, Colusa, Del Norte, El Dorado, Glenn, Humboldt, Inyo, Kings, Lake, Lassen, Mendocino, Modoc, Mono, Monterey, Nevada, Placer, Plumas, San Benito, Shasta, Sierra, Siskiyou, Sutter, Tehama, Trinity, Tulare, Tuolumne, Yuba, and Yolo.

(B) Area 2 shall include the counties of Fresno, Imperial, Kern, Madera, Mariposa, Merced, Napa, Sacramento, San Joaquin, San Luis Obispo, Santa Cruz, Solano, Sonoma, and Stanislaus.

(C) Area 3 shall include the counties of Alameda, Contra Costa, Marin, San Francisco, San Mateo, and Santa Clara**.**

(D) Area 4 shall include the counties of Orange, Santa Barbara, and Ventura.

(E) Area 5 shall include the county of Los Angeles.

(F) Area 6 shall include the counties of Riverside, San Bernardino, and San Diego.

(4) The Board may allow one or more health plans to subdivide one or more geographic regions. The Board shall determine which region or regions may be subdivided and the number of subregions into which a region will be divided. No subregion shall be smaller than one county. Plans rates may differ between subregions.

(5) Health plan rates shall be paid on a per capita basis and the per capita rate shall not be differentiated on the basis of the number of subscribers covered by one family contribution.

(b) Subscriber parent rates are as follows:

(1) Health benefit plan rates shall be based on two risk categories; geographic region of the subscriber's residence and age of the subscriber parent.

(2) The age categories for subscriber parents shall be as follows:

(A) The first age category is subscribers under the age of forty-five.

(B) The second age category is subscribers age forty-five and over.

(3) Health plans shall also be paid an additional lump sum payment for each delivery of one or more newborns to a subscriber parent while enrolled in the program.

(4) The six geographic regions for subscribers residing within the State of California shall be as follows unless they are altered pursuant to (5) below:

(A) Area 1 shall include the counties of Alpine, Amador, Butte, Calaveras, Colusa, Del Norte, El Dorado, Glenn, Humboldt, Inyo, Kings, Lake, Lassen, Mendocino, Modoc, Mono, Monterey, Nevada, Placer, Plumas, San Benito, Shasta, Sierra, Siskiyou, Sutter, Tehama, Trinity, Tulare, Tuolumne, Yuba, and Yolo.

(B) Area 2 shall include the counties of Fresno, Imperial, Kern, Madera, Mariposa, Merced, Napa, Sacramento, San Joaquin, San Luis Obispo, Santa Cruz, Solano, Sonoma, and Stanislaus.

(C) Area 3 shall include the counties of Alameda, Contra Costa, Marin, San Francisco, San Mateo, and Santa Clara.

(D) Area 4 shall include the counties of Orange, Santa Barbara, and Ventura.

(E) Area 5 shall include the county of Los Angeles.

(F) Area 6 shall include the counties of Riverside, San Bernardino, and San Diego.

(5) The Board may allow one or more health plans to subdivide one or more geographic regions. The Board shall determine which region or regions may be subdivided and the number of subregions into which a region will be divided. No subregion shall be smaller than one county. Plans rates may differ between subregions.

(6) Health plan rates shall be paid on a per capita basis and the per capita rate shall not be differentiated on the basis of number of subscribers covered by one family contribution.

(c) Subscriber Rates for AIM Infants

(1) The initial rate for subscribers entering the program as AIM infants shall be determined as follows:

(A) The rate shall be available only to health plans participating as contractors in the AIM Program and shall cover a health plan's entire service area.

(B) The rate shall cover the birth month through the end of the AIM infant's second month of life. After this period, a health plan shall be paid rates in accordance with the age and geographic region categories in subsections (a)(2), (3) and (4).

NOTE: Authority cited: Sections 12693.21 and 12693.755, Insurance Code.
Reference: Sections 12693.21, 12693.34, 12693.615 and 12693.755, Insurance Code.

2699.6803. Annual Health, Dental and Vision Benefit Plan Rates.

Health, dental and vision benefit plan rates shall be established for each rating period and the rating period for the program shall be a twelve (12) month period.

NOTE: Authority cited: Section 12693.21, Insurance Code.
Reference: Section 12693.21, Insurance Code.

2699.6804. Rural Demonstration Project(s) Payments.

In addition to plan rates, the Board may:

(a) Pay plan rate enhancement(s) to a health, dental or vision benefits plan based on the plan's participation in a rural demonstration project(s). Such rate enhancements shall be for the same period as the annual health, dental and vision benefit plan rates.

(b) Provide a grant(s) to a health, dental or vision plan based on the plan's participation in a rural demonstration project(s).

NOTE: Authority cited: Section 12693.21, Insurance Code.
Reference: Section 12693.91, Insurance Code.

2699.6805. Designation of Community Provider Plan

(a) For each benefit year, the Board will designate as the community provider plan in each county the participating health plan with a service area which includes zip codes in which at least eighty-five percent (85%) of the residents of the county reside that has the highest percentage of traditional and safety net providers pursuant to the calculation in (e) below.

(b) By the end of November of each year, the Board shall compile and make available a list for each county of all Child Health and Disability Prevention Program (CHDP), clinic and hospital traditional and safety net providers.

(c) The lists shall be compiled as follows:

(1) The CHDP list shall include all CHDP providers, except for clinical laboratories, that were on the Department of Health Services (DHS) CHDP Master File as of October 1st of that year and which provided a State-Only Funded CHDP service as identified on the CHDP Paid Claims

Tape to at least one (1) child in the state fiscal year that ended immediately prior to the most recently ended state fiscal year. For each provider, the list shall indicate the percentage of county children that received State-only funded CHDP services from the identified provider. The number of county children shall be calculated by summing the numbers of children that received State-only funded CHDP services from each listed provider.

(2) The clinic list shall include all community clinics, free clinics, rural health clinics, and county owned and operated clinics, located

in the county, which were so identified by the Medi-Cal program as of October 1st of that year and which were identified on the Medi-Cal Paid Claims Tape as having provided service to at least one (1) child aged one (1) through eighteen (18) in the state fiscal year that ended immediately prior to the most recently ended state fiscal year. For each clinic, the list shall indicate a percentage which shall be equal to one (1) divided by the number of listed clinics in the county.

(3) The hospital list shall include:

(A) For a county that has, located in the county, at least one hospital which was as of October 1st of that year a hospital eligible for the inpatient disproportionate share hospital payment program as reported by the Department of Health Services, a University teaching hospital, a Children's Hospital (as defined in Section 10727 of the Welfare and Institutions Code), or a county owned and operated general acute care hospital, the list shall include all hospitals of one of these types whether or not they are located in the county which reported to the Office of Statewide Health Planning and Development (OSHPD) discharging at least one resident of the county who was a Medi-Cal, county indigent and charity care patient aged one (1) through eighteen (18) in the year for which OSHPD most recently released its annual compilation of Discharge Data. For each hospital, the list shall indicate the percentage of the Medi-Cal, county indigent, and charity care discharges from all listed hospitals of county residents aged one (1) through eighteen (18) that were from the identified hospital.

(B) For all other counties, the list shall include all hospitals located in the county and all hospitals which discharged at least one resident of the county who was a Medi-Cal, county indigent or charity care patient aged one (1) through eighteen (18) in the year for which OSHPD most recently released its annual compilation of Discharge Data and which were a hospital eligible for the inpatient disproportionate share hospital payment program as reported by the DHS, a university teaching hospital, a children's hospital (as defined in Section 10727 of the Welfare and Institutions Code), or a county owned and operated general acute care hospital. For each hospital the list shall indicate the percentage of the Medi-Cal, county indigent, and charity care discharges from all listed

hospitals of county residents aged one (1) through eighteen (18) that were from the identified hospital.

(d) By January 15th of each year, each participating health plan shall submit to the Board for each county the following:

(1) A list of the CHDP providers identified by the Board pursuant to (c)(1) that have a contractual relationship with the participating health plan for the provision of services to program subscribers.

(2) A list of the clinics identified by the Board pursuant to (c)(2) that have a contractual relationship with the participating health plan for the provision of services to program subscribers.

(3) A list of the hospitals identified by the Board pursuant to (c)(3) that have a contractual relationship with the participating health plan for the provision of services to program subscribers.

(e) The percentage of traditional and safety net providers in the provider network of each participating health plan will be calculated by summing the CHDP percentage, the clinic percentage, and the hospital percentage.

(1) The CHDP percentage is calculated by summing the percentages assigned to all CHDP providers in the county identified by the plan pursuant to (d)(1), and multiplying that number by 0.35.

(2) The clinic percentage is calculated by summing the percentages assigned to all clinics in the county identified by the plan pursuant to (d)(2), and multiplying that number by 0.45.

(3) The hospital percentage is calculated by summing the percentages assigned to all hospitals in the county identified by the plan pursuant to (d)(3), and multiplying that number by 0.2.

(f) The Board shall announce the designation of the community provider plan for each county by March 31st of each year for the benefit year beginning on the next July 1st. Prior to designation, each plan's relationships with traditional and safety net providers may be verified by the Board.

(g) The lists of CHDP providers in (c)(1), clinics in (c)(2) and hospitals in (c)(3) shall only be revised under the following circumstances:

(1) Any CHDP provider not included on a county list pursuant to(c)(1) that believes it met the specified criteria to be on that list and was excluded in error, may within thirty (30) calendar days after the list is released by the Board, notify the Board that it so believes and

provide written documentation demonstrating that it met the listed criteria. If the Executive Director of the Board finds that the CHDP provider did meet the specified criteria it shall be added to the county list.

(2) Any clinic not included on a county list pursuant to (c)(2) that believes it met the specified criteria to be on that list and was excluded in error, may within thirty (30) calendar days after the list is released by the Board, notify the Board that it so believes and provide written documentation demonstrating that it met the listed criteria. If the Executive Director of the Board finds that the clinic did meet the specified criteria it shall be added to the county list.

(3) Any hospital not included on a county list pursuant to (c)(3) that believes it met the specified criteria to be on that list and was excluded in error, may within thirty (30) calendar days after the list is released by the Board, notify the Board that it so believes and provide written documentation demonstrating that it met the listed criteria. If the Executive Director of the Board finds that the hospital did meet the specified criteria it shall be added to the county list.

NOTE: Authority cited: Section 12693.21, Insurance Code.
Reference: Sections 12693.21, 12693.37, Insurance Code.

2699.6807. Change of Risk Category.

When a subscriber changes county of residence as specified in Section 2699.6800, or transfers between health plans pursuant to Section 2699.6619, the family contributions amount shall be recalculated and changed as of the first of the following month, unless the applicant has a family contribution sponsor.

NOTE: Authority cited: Section 12693.21, Insurance Code.
Reference: Section 12693.21, Insurance Code.

2699.6809. Determination of Family Contribution for the Program.

(a) Family child contributions for the program shall consist of one of the following:

(1) A flat fee in each county for a family value package:

(A) Seven dollars ($7) per subscriber child with a maximum required contribution of fourteen dollars ($14) per month for subscriber children with annual household incomes

after income deductions of up to and including 150 percent of the federal poverty level.

(B) Nine dollars ($9) per subscriber child with a maximum required contribution of twenty-seven dollars ($27) per month for subscriber children with annual household incomes after income deductions greater than 150 percent and up to and including 250 percent of the federal poverty level; these rates are also applicable for subscribers who entered the program as AIM infants.

(2) A flat fee in each county for a family value package that includes a community provider plan:

(A) Four dollars ($4) per subscriber child with a maximum required contribution of eight dollars ($8) per month for subscriber children with annual household incomes after income deductions of up to and including 150 percent of the federal poverty level.

(B) Six dollars ($6) per subscriber child with a maximum required contribution of eighteen dollars ($18) per month for subscriber children with annual household incomes after income deductions of greater than 150 percent and up to and including 250 percent of the federal poverty level; these rates are also applicable for subscribers who entered the program as AIM infants.

(b) Family parent contributions for the program shall consist of one of the following:

(1) A flat fee in each county for a family value package:

(A) Ten dollars ($10) per month per subscriber parent with an annual household income after income deductions of up to and including 150 percent of the federal poverty level.

(B) Twenty dollars ($20) per month per subscriber parent with an annual household income after income deductions greater than 150 percent and up to and including 200 percent of the federal poverty level.

(2) A flat fee in each county for a family value package that includes a community provider plan:

(A) Seven dollars ($7) per month per subscriber parent with an annual household income after income deductions of 150 percent of the federal poverty level.

(B) Seventeen dollars ($17) per subscriber parent with an annual household income after income deductions of greater than 150 percent and up to and including 200 percent of the federal poverty level.

(c) Applicants who pay in advance the amount of three (3) months of family child contributions shall receive the fourth consecutive month of coverage for a subscriber child with no family child contributions required.

(d) Applicants who pay in advance the amount of three (3) months of family parent contributions shall receive the fourth consecutive month of coverage for a subscriber parent with no family parent contributions required if the subscriber child contributions (if applicable) are also paid in advance, at the same time for the same three month period.

(e) Applicants who pay the family child contributions (if applicable) and the family parent contributions (if applicable) by electronic fund transfer shall receive a twenty-five (25) percent discount off the monthly combined total of the family child contributions and family parent contributions.

(f) If the applicant is applying for children in more than one household, the income of the household with the lowest annual income after income deductions will be used to determine the family contributions.

(g) If an applicant has a family contribution sponsor, family child contributions and/or family parent contributions that are to be paid by the family contribution sponsor for any twelve (12) consecutive months in the program shall be established based on subsections (a) and (b) above.

(h) If an AIM infant is enrolled in a different health plan from his or her siblings until the Open Enrollment period after the AIM infant's first birthday, the family child contribution will be the family child contribution for the siblings, plus the contribution rate for one more child at the same rate, up to the maximum required contribution.

NOTE: Authority cited: Sections 12693.21 and 12693.755, Insurance Code. Reference: Sections 12693.21, 12693.43, 12693.53 and 12693.755, Insurance Code.

2699.6811. Notification of Family Contributions Changes.

The program shall notify applicants in writing of a change in family child contributions and/or family parent contributions.

NOTE: Authority cited: Sections 12693.21 and 12693.755, Insurance Code.
Reference: Section 12693.21 and 12693.755, Insurance Code.

2699.6813. Family Contribution Payment for the Program.

Family contribution payment procedures for applicants shall be as follows unless the applicant or person for whom application is being made is an American Indian or Alaska Native and submits acceptable documentation as described in Subsection 2699.6600(c)(1)(GG), or unless the applicant has a family contribution sponsor:

(a) Applicants shall submit their initial family contributions pursuant to Subsection 2699.6600(a). The family child contributions and family parent contributions will be applied for one (1) month or four (4) months, as applicable, starting with the first day of the first full month of coverage. If the applicant or person for whom application is being made is an American Indian or Alaska Native, the family contributions shall not be assessed until the first day of the first full month following the end of the second month of enrollment during which the applicant has not provided acceptable documentation as described in Subsection 2699.6600(c)(1)(GG).

(b) Applicants shall submit their subsequent family contributions to the program so that they are received no later than the monthly due date set by the program.

(c) The program shall apply monies paid first to the family child contributions due, then to the family parent contributions due. Remaining monies shall be applied first to the family child contribution up to the level necessary to earn a free month of coverage, then to the family parent contribution up to the level necessary to earn a free month of coverage, except as provided under Subsection 2699.6605(b)(1).

(d) Applicants who want to receive the one month family contribution discount pursuant to Subsection 2699.6809(c) and (d) must submit their family child contributions, if applicable, and/or family parent contributions, if applicable, at the same time and for the same three (3) month period so that they are received no later than the due date set by the program for the first of the three (3) months.

(e) For each month any family contributions are due, the program shall notify the applicant of the amount of the family contributions due to the program, the due date, and the subscribers for whom the family contributions are being paid. This notification shall be made at least fifteen (15) calendar days in advance of the family contributions due date.

(f) The applicant's obligation to submit the family contributions is not contingent upon receipt of the notice specified in subdivision (d) above. If the applicant does not receive the notice specified in subdivision (d) above, the applicant shall call the program to determine the amount of the family contributions and shall submit a payment of that amount.

(g) Applicants shall make family contributions in one or more of the following ways: personal check, cashiers check, money order, credit card, debit card, electronic fund transfer, or in cash at designated locations. If a family contribution is paid by a personal check that has been returned for non-sufficient funds, the Program may specify the form of payment that it will accept for the overdue family contribution.

(h) If a subscriber is disenrolled pursuant to Subsection 2699.6611(a), the applicant will be refunded the unused portion of the family contributions, except as provided in Section 2699.6815(e) and Section 2699.6819(c).

NOTE: Authority cited: Sections 12693.21 and 12693.755, Insurance Code. Reference: Sections 12693.21, 12693.43 and 12693.755, Insurance Code.

2699.6815. Overdue Payments; Disenrollment.

(a) Applicants whose family child or parent contributions are not paid in full by the due date shall be considered to be overdue.

(b) The program shall notify applicants of the overdue family child and/or parent contributions and the potential for disenrollment from the program within fifteen (15) calendar days following the due date.

(c) No less than thirty (30) calendar days prior to the date of potential disenrollment pursuant to (e) and (f) below, the program shall provide notice to the applicant of the potential disenrollment as specified in Subsection 2699.6611(b).

(d) If the amount of family contributions paid by an applicant is not adequate to cover the combined amount of the family child contributions and family parent contributions, the program will first apply the monies paid toward the family child contributions with any remainder applied toward the family parent contributions.

(e) If family parent contributions are not paid for two (2) consecutive calendar months, the subscriber parents covered by the family contribution shall be disenrolled pursuant to Section 2699.6611. Termination of coverage shall be at the end of the second consecutive month for which the family parent contributions were not paid in full. Any credit remaining

from the family parent contributions after a subscriber parent's disenrollment from the program will be applied toward any family child contributions applicable to a subscriber child who is enrolled in the program and to whom the subscriber parent is linked.

(f) If family child contributions are not paid for two (2) consecutive calendar months, all subscriber children covered by the family child contributions shall be disenrolled pursuant to Section 2699.6611. Termination of coverage shall be at the end of the second consecutive month for which the family child contributions were not paid in full.

NOTE: Authority cited: Sections 12693.21 and 12693.755, Insurance Code.
Reference: Sections 12693.21, 12693.45 and 12693.755, Insurance Code.

2699.6817. Family Contribution Sponsor Registration.

(a) Family contribution sponsors must register with the Board.

(b) To be registered, a family contribution sponsor must:

(1) complete and return a Healthy Families Program Family Contribution Sponsor Registration form (HFP-Sponsor 1(new 7/00)), which is hereby incorporated by this reference, and

(2) receive a sponsor identification number from the Board.

NOTE: Authority cited: Section 12693.21, Insurance Code.
Reference: Sections 12693.21, Insurance Code.

2699.6819. Family Contribution Sponsor Payments.

(a) For each applicant being sponsored, the family contribution sponsor shall submit payment for twelve (12) months of family child contributions if the family contribution sponsor is sponsoring a subscriber child, and twelve (12) months of family parent contributions if the family contribution sponsor is sponsoring a subscriber parent. The family contribution sponsor shall also submit the completed and signed Healthy Families Program Family Contribution Sponsorship Payment form (HFP-Sponsor 2 (new 7/00)) which is hereby incorporated by this reference.

(b) The payment for twelve (12) months of family child contributions shall be the family child contributions amount determined pursuant to Subsection 2699.6809(e) multiplied by 12. The payment for twelve (12) months of family parent contributions shall be the family parent contributions amount determined pursuant to Subsection 2699.6809(f) multiplied by 12.

(c) Payment of the amount specified in subsection (b) above shall be considered payment in full for the applicant for the twelve (12) consecutive months in the Program or, as of the parental coverage start date, for any twelve consecutive months in the program. No premium adjustments will be made for any reason during the period.

NOTE: Authority cited: Sections 12693.21 and 12693.755, Insurance Code.
Reference: Sections 12693.21 and 12693.755, Insurance Code.

2699.6821. Eligibility as a Family Contribution Sponsor.

(a) The following persons or entities are not eligible to be family contribution sponsor:

(1) a person that is a health care, dental care or vision care provider that participates in the Healthy Families Program or an organization composed primarily of or controlled by such persons,

(2) an entity, including governmental, school, non-profit and charitable organizations, that is ,or that operates, an institution or facility that is a health care, dental care or vision care provider that participates in the Healthy Families Program.

(3) a participating plan.

(4) any person or entity acting on behalf of or representing a person or entity identified in (1) through (3) above.

NOTE: Authority cited: Section 12693.21, Insurance Code.
Reference: Section 12693.21, Insurance Code.

2699.6823. Family Contribution Sponsor Certification Requirement.

(a) Any person or entity seeking to provide payment as a family contribution sponsor must certify both of the following:

(1) that the person or entity is not ineligible to be family contribution sponsor under Section 2699.6821, and

(2) that the person or entity acknowledges that the board has taken no position as to whether payment of premiums as a family contribution sponsor by any person or entity would be in violation of federal fraud and abuse laws.

(b) The certification shall be made on the Healthy Families Program Family Contribution Registration form (HFP-Sponsor 1 (new 7/00)).

NOTE: Authority cited: Section 12693.21, Insurance Code.
Reference: Section 12693.21, Insurance Code.

2699.6825. Family Contribution Sponsor Disqualification.

The Board may refuse to allow a registered family contribution sponsor to sponsor any additional applicants if the Board determines that the sponsor has violated or encouraged an applicant to violate program rules. The sponsor will be notified in writing of such a determination. The sponsor may appeal the determination by filing a written request for review by the Executive Director.

NOTE: Authority cited: Section 12693.21, Insurance Code.
Reference: Section 12693.21, Insurance Code.

2699.6827. Payment of State Supported Services.

State Supported Services shall be paid for by State dollars only. No Federal dollars provided to the State pursuant to title XXI of the Social Security Act shall be used.

NOTE: Authority cited: Section 12693.21, Insurance Code.
Reference: Section 12693.21, Insurance Code and 42 CFR Section 457.475.

ARTICLE 5: CHILD HEALTH AND DISABILITY PREVENTION PROGRAM PAYMENTS

2699.6900. Child Health and Disability Prevention Program Providers.

(a) For purposes of meeting the requirements of Insurance Code Section 12693.41, regarding reimbursement of providers who participate in the Child Health and Disability Prevention (CHDP) Program, providers are defined as:

(1) CHDP health assessment providers, are those individuals and entities described in Title 17, California Code of Regulations, Section 6860 and 6862, who provide well-child health assessment and immunizations.

(2) CHDP initial treatment providers, are those providers that participate in the Medi-Cal and Denti-Cal program and provide initial treatment of a condition that has been identified during the well-child health assessment.

NOTE: Authority Cited: Section 12693.21, Insurance Code.
Reference: Section 12693.41, Insurance Code.

2699.6903. Reimbursable Services.

(a) For purposes of meeting the requirements of Insurance Code Section 12693.41 relating to the Healthy Families Program reimbursements, a "CHDP well-child health assessment" is as defined in Title 17, California Code of Regulations, Section 6800 and shall include those services specified in Title 17, California Code of Regulations, Section 6846.

(b) For purposes of meeting the requirements of Insurance Code Section 12693.41 relating to the Healthy Families Program reimbursement, "initial treatment" means those services provided in the 90 days prior to a person's effective date of coverage by a Healthy Families Program participating health plan that are necessary for diagnosis and treatment of a condition identified during the "CHDP well-child health assessment". These services may include, but are not limited to:

(1) Outpatient physician services including referral to outpatient specialty care, laboratory services, x-ray services, prescription drugs and those medical supplies and equipment necessary to administer prescribed medication.

(2) Inpatient hospital care.

(3) Emergency dental services that are medically necessary for the relief of pain and treatment of infection.

NOTE: Authority cited: Section 12693.21, Insurance Code.
Reference: Section 12693.41, Insurance Code.

2699.6905. Reimbursement Rates.

(a) For the purposes of meeting the requirement of Insurance Code Section 12693.41 relating to the Healthy Families Program, wellchild health assessments and immunizations provided to persons who subsequently enroll in the Healthy Families Program pursuant to Article 2, shall be reimbursed at the rates specified in Title 17, California Code of Regulations, Section 6868. CHDP health assessment providers shall submit claims for these services in accordance with Title 17, California Code of Regulations, Section 6866 to the State Department of Health Services (DHS).

(b) For purposes of meeting the requirement of Insurance Code Sections 12693.41 relating to the Healthy Families Program, providers shall be reimbursed for initial treatment provided to persons who subsequently enroll in the Healthy Families Program pursuant to Article 2, at the Medi-Cal rate, as specified in Title 22, California Code of Regulations, Sections 51501 et. seq. A county that reimburses provider at a county-specific rate that is less than the Medi-Cal rate for treatment services for a condition identified in a CHDP health assessment will be reimbursed by the Healthy Families Program at the rate the county reimburses the treatment provider. Providers shall submit claims to the DHS for these services on the Health Insurance Claim Form (HCFA 1500, revised version 12/90), accompanied by a legible copy of any DHS approved version of the Confidential Screening/Billing Report (PM 160).

NOTE Authority cited: Section 12693.21, Insurance Code.
Reference: Section 12693.41, Insurance Code.

ENCLOSURE 3

2004 Federal Income Guidelines

Healthy Families Program and Medi-Cal for Families
2004 Income Guideline Chart

Family Size	Child Age 0 to 1 or Pregnant Woman Medi-Cal	Child Age 0 to 1 Healthy Families	Child Age 1 thru 5 Medi-Cal	Child Age 1 thru 5 Healthy Families	Child Age 6 thru 18 Medi-Cal	Child Age 6 thru 18 Healthy Families	All Children under age 19 between 250% to 300%
1	$0 -$1,552	$1,553 - $1,940	$0 - $1,032	$1,033 - $1,940	$0 - $776	$777 - $1,940	$1,941 - $2,328
2	$0 -$2,082	$2,083 - $2,603	$0 - $1,385	$1,386 - $2,603	$0 - $1,041	$1,042 - $2,603	$2,604 –$3,123
3	0 - $2,612	$2,613 - $3,265	$0 –$1,737	$1,738 - $3,265	$0 –$1,306	$1,307 - $3,265	$3,266 - $3,918
4	$0 -$3,142	$3,143 - $3,928	$0 - $2,090	$2,091 - $3,928	$0 - $1,571	$1,572 - $3,928	$3,929 - $4,713
5	$0 -$3,672	$3,673 - $4,590	$0 - $2,442	$2,443 - $4,590	$0 - $1,836	$1,837 - $4,590	$4,591 - $5,508
6	$0 -$4,202	$4,203 - $5,253	$0 - $2,795	$2,796 - $5,253	$0 - $2,101	$2,102- $5,253	$5,254 - $6,303
7	$0 -$4,732	$4,733 - $5,915	$0 - $3,147	$3,148 - $5,915	$0 - $2,366	$2,367 - $5,915	$5,916 - $7,098
8	$0 -$5,262	$5,263 - $6,578	$0 - $3,499	$3,500 - $6,578	$0 - $2,631	$2,632 - $6,578	$6,579 - $7,893
9	$0 -$5,792	$5,793 - $7,240	$0 - $3,852	$3,853 - $7,240	$0 - $2,896	$2,897 - $7,240	$7,241 –$8,688
10	$0 -$6,322	$6,323 - $7,903	$0 - $4,204	$4,205 - $7,903	$0 - $3,161	$3,162 - $7,903	$7,904 –$9,483
Add the following dollar amount for each additional family member:							
	$530	$531 - $663	$353	$354 - $663	$265	$266 - $663	$664 - $795

Healthy Families Program 2004 Premium Categories		
Family Size	Category A	Category B
1	$777 - $1,164	$1,164.01 - $1,940
2	$1,042 - $1,561	$1,561.01 - $2,603
3	$1,307 - $1,959	$1,959.01 - $3,265
4	$1,572 - $2,356	$2,356.01 - $3,928
5	$1,837 - $2,754	$2,754.01 - $4,590
6	$2,102 - $3,151	$3,151.01 - $5,253
7	$2,367 - $3,549	$3,549.01 - $5,915
8	$2,632 - $3,946	$3,946.01 - $6,578
9	$2,897 - $4,344	$4,344.01 - $7,240
10	$3,162 - $4,741	$4,741.01 - $7,903
Each Additional Family Member	$266 - $398	$398.01 - $663

ENCLOSURE 4

Sample Applicant Correspondence

MRMIB has many templates (letters, notices. instructions, etc.) developed for HFP. These documents could very easily be adapted for C-CHIP and save applicants time and effort. The following are sample letters that MRMIB would be more than willing to share with counties implementing C-CHIP.

WELCOME LETTER (SAMPLE)

Month Day, Year]
[Applicant Name]
[Address 1]
[Address 2]
[City, State Zip]
Family Member Number: [Family Member Number]

Dear Applicant:

Thank you for asking about the Healthy Families and Medi-Cal Programs. These programs provide low-cost or free health care coverage. There is an application form with this letter that you can use to apply for Healthy Families and Medi-Cal.

What you have to do
1. Fill out the application so we can see if your family meets the Healthy Families or Medi-Cal program rules.

2. Make copies of these important papers:
* proof of income, such as copies of current pay stubs (within 45 days) or last year's Federal Income Tax Form (1040); and
* copies of birth certificates or immigration papers; and
* copies of child support or alimony paid, and child care expense bills.
See page 6 of the application form for a complete list of the papers you will need to send.

3. Mail the application form with the copies of the important papers. Use the envelope that is inside the application form. You do not need a stamp.
Healthy Families Handbook

The Healthy Families Handbook tells how the program works. If you qualify for Healthy Families, you will need to choose a health plan, dental plan and vision plan. You will get your health care from the doctors and other providers in these plans.
If you want to choose these plans now, look at the Healthy Families Handbook for information on the plans, and write down your choices on page A4 of the application. If you do not choose the plans now, we will ask you to choose them later.
What happens next?

When we receive your form, we will look at it and let you know if you can get Healthy Families, or if we need to send your application to Medi-Cal.
Questions?
If you have any questions, please call 1-800-880-5305, Monday to Friday, 8 a.m. to 8 p.m., or on Saturday, 8 a.m. to 5 p.m. The call is free. We can help you fill out the application form over the phone. We can also give you the name and phone number of someone in your area who can help you fill out the application form at no cost to you.

Thank you,
Healthy Families and Medi-Cal Programs

INFORMATION REQUESTED SAMPLE LETTER

Month Day, Year]
[Applicant Name]
[Address 1]
[Address 2]
[City, State Zip]
Family Member Number: [Family Member Number]

Dear Applicant:

Recently you sent us a Healthy Families application. Before we can make a decision, you must send your first month premium payment and anything you owe from the past. Here is what you owe:
One Month Premium: [Child Payable Amount $$$]
Premium Past Due, if any: [Premium Arrears $$$]
Amount You Paid, if any: [Amount Paid $$$]
Required Amount to Begin Coverage:[Balance Due $$$]

What you have to do
Write a check to "Healthy Families Program" for [Balance Due $$$]
1. Write your family member number on the check. Your Family Member Number is [FMN]

2. Mail the check so that we get it by [Month Day, Year]
Healthy Families Program
Attn: Eligibility Review
P.O. Box 138005
Sacramento, CA 95813-8005

What happens next?
We will tell you if your family member can join Healthy Families. You may need to send a new application form if we get your payment after [month, day year].
Questions?

If you have any questions, call 1-866-848-9166, Monday to Friday, 8 a.m. to 8 p.m., or on Saturday, 8 a.m. to 5 p.m. The call is free.

Thank you,
Healthy Families Program

CERTIFICATE OF CREDITABLE COVERAGE SAMPLE LETTER

[Month Day, Year]
[Applicant Name]
[Address 1]
[Address 2]
[City, State Zip]
Family Member Number: [Family Member Number]

Dear Applicant:

This letter has information that you may need if someone in your family has a health problem. This letter is a certificate of creditable coverage. Please keep it to show to a new health plan if you join one by [Month, Day, Year].

The Healthy Families Program does not provide health coverage any longer to
[person]
[person]
[person].

You may want to get health coverage for your family members from a new health plan. If your family member has a health problem before joining the new plan, this is called a "pre-existing condition." When someone has a pre-existing condition, the new health plan may not cover all necessary health care for a period of time (called a waiting period). If your new health plan has a waiting period, this letter may help you to get health care sooner.

When someone's health coverage ends, and the person enrolls in (joins) a new health plan within 63 days (not including a waiting period), the new plan must count the time that the person was covered in the old health plan in any pre-existing waiting period.

What you have to do
If your family member has a health problem and joins a new health plan by [Month, Day, Year]:

1. Make a copy of this letter.

2. Call your new health plan. Ask them "Do you have a waiting period for pre-existing conditions?" If they say "yes," tell them "My family member has a pre-existing condition. I have a certificate to get credit for the time we were covered before we joined your health plan. Where should I mail this certificate?"

3. Mail the copy of this letter to the address your health plan gives you.

If your new plan says you still have a waiting period
Your new health plan may tell you that you will still have a waiting period, because your family member did not get enough credit for the time that you were in Healthy Families. If your family member was in another health plan before Healthy Families, you may be able to get health coverage from your new plan sooner. Call your old health plan and tell them, "I would like to get a certificate to get credit for the time that I was in your health plan." Then send a copy of the certificate to your new health plan.
(See next page.)

Information for your new health plan
This is the information that your new health plan may need:

Client Index Number (CIN)	Enrolled	Disenrolled	Credit Earned	Family Member
[CIN]	[Mo,Day,Yr]	[Mo,Day,Yr]	[# months]	[Name 1]
[[CIN]	[Mo,Day,Yr]	[Mo,Day,Yr]	[# months]	[Name 2]
[[CIN]	[Mo,Day,Yr]	[Mo,Day,Yr]	[# months]	[Name 3]
[[CIN]	[Mo,Day,Yr]	[Mo,Day,Yr]	[# months]	[Name 4]

Questions?

If you have any questions, please call 1-866-848-9166, Monday to Friday, 8 a.m. to 8 p.m., or on Saturday, 8 a.m. to 5 p.m. The call is free.

Thank you,
Healthy Families Program

DISENROLLMENT SAMPLE LETTER

[Month Day, Year]
[Applicant Name]
[Address 1]
[Address 2]
[City, State Zip]
Family Member Number: [Family Member Number]

Dear Applicant:

The Healthy Families Program does not provide health coverage any longer to the following people for the reasons listed below

[Name1]	[reason text]
[Name2]	[reason text]
[Name3]	[reason text]
[Name4]	[reason text]

You may have to pay for the health, dental, and vision services that these family members get after [Month, Day, Year].
[We received your payment and applied it to your past due amount.]
If you think we made a mistake
If you think we made the wrong decision, you can ask us for a review. To ask for a review:

1. Fill out the Program Review form that came with this letter. Tell us why you think your children can still get Healthy Families coverage. You can also send any other papers or information that you would like us to see. We cannot do a review over the phone. Write your Family Member Number on each paper. Your Family Member Number is: [FMN]

2. Mail your Program Review form and any other papers to:

Healthy Families Program
Attention: Review Unit
P.O. Box 138005
Sacramento, CA 95813-8005
Or, you can fax to: 1-866-848-4974. The fax number is free.

We must get your form by [Month, Day, Year].

If we receive your Program Review form after this date we cannot review it, and you will have to fill out a new application.

If you want to enroll your child again
If you think your family members meet the program rules and can now get Healthy Families, you can ask us to enroll them again.
1. Fill out the Re-enrollment form that came with this letter.

2. Make copies of these papers:
* proof of income, such as copies of pay stubs;
* checks or bills that show that you paid child care, child support, or alimony.

3. Call 1-888-848-9166 and say: "I want to re-enroll my children in Healthy Families. How much will my premium bill be?"

4. Write a check or money order to "Healthy Families Program" for this amount.

5. Mail the Re-enrollment form, copies of your papers, and check to the address above for the Program Review form.

Please send this form to us before [Month, Day, Year].
If you send the Re-enrollment form after this date, you will have to fill out a new application form.
What happens next?
When we get your Re-enrollment form, we will look at the information and we will let you know if your child can get Healthy Families.
Questions?

If you have questions, please call 1-866-848-9166, Monday to Friday, 8 a.m. to 8 p.m., or on Saturday, 8 a.m. to 5 p.m. The call is free.

Thank you,
Healthy Families Program

ENCLOSURE 5

HFP/C-CHIP Health Benefits and Co-Payment Matrix

(Enclosure 5)
HFP/C-CHIP Health Benefits and Co-Payments for:

_____

Name

Please fill in name and the C-CHIP shaded columns

HFP Health Benefit	**HFP Copay for Health Benefit**	**C-CHIP Health Benefit Provided (yes/no)**	**C-CHIP Copay for Health Benefit**
Health Facilities: Inpatient Hospital Service	$0		$
Outpatient Hospital Services	$5		$
Professional Services: Surgery	$0		$
Assistant Surgery and Anesthesia	$0		$
Inpatient Hospital and Skilled Nursing Visits	$0		$
Professional Office Visits	$5		$
Home Visits, When Medically Necessary	$0		$
Hearing Tests	$0		$
Eye Examinations	$0		$
Hearing Aids and Services	$0		$
Immunizations	$0		$
Periodic Health Examinations	$0		$

Well baby Care	$0		$
Diagnostic X-Ray Services	$0		$
Laboratory Services	$0		$
Prescription Drugs: Inpatient	$0		$
Maintenance drugs (90-100 days supply)	$5		$
FDA approved contraceptive drugs and devices	$0		$
Brand name/generic drugs on an outpatient basis	$5		$
Durable Medical Equipment: Appropriate for home purpose --- oxygen and oxygen equip	$0		$
--- blood glucose monitor	$0		$
--- apnea monitors	$0		$
--- insulin pumps and related supplies	$0		$
--- supplies consistent with Medicare Coverage guidelines	$0		$
Orthotics and Prosthetics	$0		$
Cataract Spectacles and Lenses	$0		$
Maternity Care	$0		$

Family Planning	$0		$
Medical Transportation Services	$0		$
Emergency Health Care Services: Emergency Room Visit – emergency	$5		$
Emergency Room Visit – reasonable belief of emergency condition existed	$5		$
Mental Health Inpatient (30 days per benefit year)	$0		$
Outpatient (20 visits per benefit year)	$5		$
Alcohol and Drug Abuse: Inpatient	$0		$
Outpatient (minimum of 20 visits per benefit year)	$5		$
Home Health Services	$0		$
Skilled Nursing Care	$0		$
Physical, Occupational, and Speech Therapy: Inpatient	$0		$
Outpatient	$5		$
Acupuncture Services(optional)	$5		$
Chiropractic Services (optional)	$5		

Biofeedback (optional)	$5		
Blood and Blood Products	$0		$
Health Education	$0		$
Hospice	$0		$
Transplants	$0		$
Reconstructive Surgery	$0		$
Maximum health benefit copayment per benefit year (July 1-June 30)	$250		$

ENCLOSURE 6

HFP/C-CHIP Dental Benefits and Co-Payment Matrix

Enclosure 6

HFP/C-CHIP Dental Benefits and Co-Payments for:

_____

Name

Please fill in name and the C-CHIP shaded columns

HFP Dental Benefit	**HFP Copay for Dental Benefit**	**C-CHIP Dental Benefit Provided (yes/no)**	**C-CHIP Copay for Dental Benefit**
Diagnostic and Preventative Services	$0		$
Restorative Dentistry	$0		$
Oral Surgery	$0		$
Removal of impacted teeth – Soft tissue impaction	$0		$
Removal of impacted teeth – Bony tissue impaction (per tooth)	$5		$
Endodontics	$0		$
Root canal-therapy (per canal)	$5		$
Apicoectomy with root canal (per canal)	$5		$
Peridontics	$0		$
Osseous or musco-Gingival surgery (per quadrant)	$5		$
Gingivectomy	$0		$

Crowns and Fixed Bridges	$0		$
Porcelain crowns, porcelain fused to metal crowns; full metal crowns; gold onlays or ¾ crown	$5		$
Pontics	$5		$
Removable Prosthetics	$0		$
Dentures (complete maxillary, complete mandibar, partial acrylic upper or lower with clasps, partial up per or lower with chrome cobalt alloy lingual or palatal bar, clasps and acrylic saddles)	$5		
Reline upper, lower or partial denture: Office reline	$0		$
Laboratory reline	$5		$
Denture duplication	$5		$
Other Dental Benefits	$0		$

ENCLOSURE 7

HFP/C-CHIP Vision Benefits and Co-Payment Matrix

(Enclosure 7)

HFP/C-CHIP Vision Benefits and Co-Payments for:

_____

Name

Please fill in name and the C-CHIP shaded columns

HFP Vision Benefit	**HFP Copay for Vision Benefit**	**C-CHIP Vision Benefit Provided (yes/no)**	**C-CHIP Copay for Vision Benefit**
Examinations	$5		$
Frames and Lenses	$5		$
Contact Lenses Necessary	$0		$
Elective	Allowance		$
Low Vision Benefits Supplemental testing	$0		$
Supplemental care	$5		$

ENCLOSURE 8

HFP/C-CHIP Premiums Matrix

(Enclosure 8)

HFP/C-CHIP Premiums for:

_____

Name

Fill in name and shaded C-CHIP row

Program	Premium Amount	Payments Due Monthly/Quarterly	Discounts
HFP	$4 - $9 per month per child ($27 maximum per month)	Monthly	Pay 3 months get the 4th free; 25% discount if paid by EFT
C-CHIP	$ ____ per month per child		

ENCLOSURE 9

Sample C-CHIP Invoice Form

SAMPLE C-CHIP INVOICE

State of California - Managed Risk Medical Insurance Board ***Confidential***

The County Children's Health Initiative (C-CHIP) Program Invoice and Report

MRF- xx (new- August 2003)

This form is confidential in accordance with Government Code Section 6254

The County Children's Health Initiative Program (C-CHIP)

Contract Number	**Invoice Number**	**Invoice Date**	**Month of Service**	**County Code**
xxxxx	CCHIP-01			

Organization Name **Organization Address**	**Organization Contact Person** *Name* *Title* *Phone* *Email* *Address*

Category	**Total**	**Federal Share**	**County Share**
Benefits			
Capitation			
Number of Enrollees _____ times $_____ Capitation Rate			
Under age one			
Age one through age 18			
Adjustments			
Total Benefits			
less family contributions			
Net Total Benefits			
Administration - 10% limit			
State Administrative Services (X%)			
Actual County Administrative Services (X% = 10% cap less State X %)			
Total Administration (10%) limitation			

Total Benefits and Administration			
Amount Payable to the CHIM fund			$ -
Amount Reimbursable to the County	$ -	$ -	$ -

If you have not received payment by ___due date, please call ___(MRMIB Contact person) at __(phone and email address)__

ENCLOSURE 10

Sample C-CHIP Enrollment and Expenditures Budget Form

(Enclosure 10)

(SAMPLE) COUNTY CHILDREN'S HEALTH INITIATIVES MATCHING FUND PROGRAM (C-CHIP)

ACTUAL AND PROJECTED MONTHLY EXPENDITURES

DATE SUBMITTED: _____

COUNTY/PROGRAM NAME: _____

CONTACT NAME: _____

CONTACT TELEPHONE # _____

CONTACT E-MAIL ADDRESS: _____

Monthly Expenditures: Please provide actual or projected expenditures (indicate actual expenditures in **bold**).

	BENEFITS	ADMINISTRATION	TOTAL EXPENDITURES	
Jul-03			$0	
Aug-03			$0	
Sep-03			$0	
Oct-03			$0	
Nov-03			$0	
Dec-03			$0	
Jan-04			$0	
Feb-04			$0	
Mar-04			$0	
Apr-04			$0	
May-04			$0	
Jun-04			$0	State Fiscal Year 2003-04
Jul-04			$0	
Aug-04			$0	
Sep-04			$0	
Oct-04			$0	
Nov-04			$0	
Dec-04			$0	
Jan-05			$0	
Feb-05			$0	
Mar-05			$0	
Apr-05			$0	

May-05		$0	
Jun-05		$0	State Fiscal Year 2004-05

COMMENTS:

ENCLOSURE 11

How to Navigate to the California SPA on CMS Web Page

(Enclosure 11)

How to Navigation to CA SPA on CMS Web Page

- Go to http://www.cms.hhs.gov
- Click on --- Centers for Medicare & Medicaid Services
- Click on --- SCHIP (on left side menu)
- Click on --- State Programs (right side menu)
- Click on --- CA (on map)
- Click on --- CA SCHIP Plan & Amendments (under California SCHIP Information)
- Scroll to Seventh Amendment – County and AIM Eligibility Expansion

Listing includes correspondence between MRMIB and CMS (Proposals, Requests for Clarification, Responses to Requests, and Approval Letter) from March 31, 2003 to June 10, 2004.

ENCLOSURE 12

SPA #2 Proposed Timeline

(Enclosure 12)

SPA #2 Proposed Timeline

ACTIVITY	**DATE**
Application document available to interested entities	July 29, 2004
Respond to questions and inquiries from potential applicants and interested entities	August/September
Applications due to MRMIB	**October 1, 2004**
Compliance reviews conducted by MRMIB (questions and requests of applicants as necessary)	October-November
Development of SPA	December-January 2005
Submit SPA to CMS	**March 2005**

ENCLOSURE 13

SPA Template

MODEL APPLICATION TEMPLATE FOR
STATE CHILD HEALTH PLAN UNDER TITLE XXI OF THE SOCIAL SECURITY ACT
STATE CHILDREN'S HEALTH INSURANCE PROGRAM

Preamble

Section 4901 of the Balanced Budget Act of 1997 (BBA) amended the Social Security Act (the Act) by adding a new title XXI, the State Children's Health Insurance Program (SCHIP). Title XXI provides funds to states to enable them to initiate and expand the provision of child health assistance to uninsured, low-income children in an effective and efficient manner. To be eligible for funds under this program, states must submit a state plan, which must be approved by the Secretary. A state may choose to amend its approved state plan in whole or in part at any time through the submittal of a plan amendment.

This model application template outlines the information that must be included in the state child health plan, and any subsequent amendments. It has been designed to reflect the requirements as they exist in current regulations, found at 42 CFR Part 457. These requirements are necessary for state plans and amendments under Title XXI.

The Department of Health and Human Services will continue to work collaboratively with states and other interested parties to provide specific guidance in key areas like applicant and enrollee protections, collection of baseline data, and methods for preventing substitution of Federal funds for existing state and private funds. As such guidance becomes available; we will work to distribute it in a timely fashion to provide assistance as states submit their state plans and amendments.

MODEL APPLICATION TEMPLATE FOR
STATE CHILD HEALTH PLAN UNDER TITLE XXI OF THE SOCIAL SECURITY ACT
STATE CHILDREN'S HEALTH INSURANCE PROGRAM

(Required under 4901 of the Balanced Budget Act of 1997 (New section 2101(b)))

State/Territory:_____
(Name of State/Territory)

As a condition for receipt of Federal funds under Title XXI of the Social Security Act, **(42 CFR, 457.40(b))**

_____
(Signature of Governor, or designee, of State/Territory, Date Signed)

submits the following State Child Health Plan for the State Children's Health Insurance Program and hereby agrees to administer the program in accordance with the provisions of the approved State Child Health Plan, the requirements of Title XXI and XIX of the Act (as appropriate) and all applicable Federal regulations and other official issuances of the Department.

The following state officials are responsible for program administration and financial oversight **(42 CFR 457.40(c))**:

Name: Position/Title:
Name: Position/Title:
Name: Position/Title:

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0707. The time required to complete this information collection is estimated to average 160 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, P.O. Box 26684, Baltimore, Maryland 21207 and to the Office of the Information and Regulatory Affairs, Office of Management and Budget, Washington, D.C. 20503.

Section 1. General Description and Purpose of the State Child Health Plans and State Child Health Plan Requirements (Section 2101)

1.1. The state will use funds provided under Title XXI primarily for (Check appropriate box) (42 CFR 457.70):

1.1.1. ☐ Obtaining coverage that meets the requirements for a separate child health program **(Section 2103); OR**

1.1.2. ☐ Providing expanded benefits under the State's Medicaid plan **(Title XIX); OR**

1.1.3. ☐ A combination of both of the above.

1.2. ☐ Please provide an assurance that expenditures for child health assistance will not be claimed prior to the time that the State has legislative authority to operate the State plan or plan amendment as approved by CMS. **(42 CFR 457.40(d))**

1.3. ☐ Please provide an assurance that the state complies with all applicable civil rights requirements, including title VI of the Civil Rights Act of 1964, title II of the Americans with Disabilities Act of 1990, section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, 45 CFR part 80, part 84, and part 91, and 28 CFR part 35. **(42CFR 457.130)**

1.4. ☐ Please provide the effective (date costs begin to be incurred) and implementation (date services begin to be provided) dates for this plan or plan amendment **(42 CFR 457.65):**

Effective date:

Implementation date:

Section 2. General Background and Description of State Approach to Child Health Coverage and Coordination **(Section 2102 (a)(1)-(3)) and (Section 2105)(c)(7)(A)-(B))**

2.1. Describe the extent to which, and manner in which, children in the state including targeted low-income children and other classes of children, by income level and other relevant factors, such as race and ethnicity and geographic location, currently have creditable health coverage (as defined in 42 CFR 457.10). To the extent feasible, make a distinction between creditable coverage under public health insurance programs and public-private partnerships (See Section 10 for annual report requirements). **(42 CFR 457.80(a))**

2.2. Describe the current state efforts to provide or obtain creditable health coverage for uncovered children by addressing: **(Section 2102)(a)(2) (42CFR 457.80(b))**

2.2.1. The steps the state is currently taking to identify and enroll all uncovered children who are eligible to participate in public health insurance programs (i.e. Medicaid and state-only child health insurance):

2.2.2. The steps the state is currently taking to identify and enroll all uncovered children who are eligible to participate in health insurance programs that involve a public-private partnership:

2.3. Describe the procedures the state uses to accomplish coordination of SCHIP with other public and private health insurance programs, sources of health benefits coverage for children, and relevant child health programs, such as title V, that provide health care services for low-income children to increase the number of children with creditable health coverage**.** ***(Previously 4.4.5.)*** **(Section 2102)(a)(3) and 2102(c)(2) and 2102(b)(3)(E)) (42CFR 457.80(c))**

Section 3. Methods of Delivery and Utilization Controls (Section 2102)(a)(4))

☐ **Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan,** and continue on to Section 4.

3.1. Describe the methods of delivery of the child health assistance using Title XXI funds to targeted low-income children. Include a description of the choice of financing and the methods for assuring delivery of the insurance products and delivery of health care services covered by such products to the enrollees, including any variations. **(Section 2102)(a)(4) (42CFR 457.490(a))**

3.2 Describe the utilization controls under the child health assistance provided under the plan for targeted low-income children. Describe the systems designed to ensure that enrollees receiving health care services under the state plan receive only appropriate and medically necessary health care consistent with the benefit package described in the approved state plan. **(Section 2102)(a)(4) (42CFR 457.490(b))**

Section 4. Eligibility Standards and Methodology. **(Section 2102(b))**

☐ **Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan,** and continue on to Section 5.

4.1. The following standards may be used to determine eligibility of targeted low-income children for child health assistance under the plan. Please note whether any of the following standards are used and check all that apply. If applicable, describe the criteria that will be used to apply the standard. **(Section 2102)(b)(1)(A)) (42CFR 457.305(a) and 457.320(a))**

4.1.1. ☐ Geographic area served by the Plan:
4.1.2. ☐ Age:
4.1.3. ☐ Income:
4.1.4. ☐ Resources (including any standards relating to spend downs and disposition of resources):
4.1.5. ☐ Residency (so long as residency requirement is not based on length of time in state):
4.1.6. ☐ Disability Status (so long as any standard relating to disability status does not restrict eligibility):
4.1.7. ☐ Access to or coverage under other health coverage:
4.1.8. ☐ Duration of eligibility:
4.1.9. ☐ Other standards (identify and describe):

4.2. The state assures that it has made the following findings with respect to the eligibility standards in its plan: **(Section 2102)(b)(1)(B)) (42CFR 457.320(b))**

4.2.1. ☐ These standards do not discriminate on the basis of diagnosis.
4.2.2. ☐ Within a defined group of covered targeted low-income children, these standards do not cover children of higher income families without covering children with a lower family income.
4.2.3. ☐ These standards do not deny eligibility based on a child having a pre-existing medical condition.

4.3. Describe the methods of establishing eligibility and continuing enrollment. **(Section 2102)(b)(2)) (42CFR 457.350)**

4.3.1. Describe the state's policies governing enrollment caps and waiting lists (if any). **(Section 2106(b)(7)) (42CFR 457.305(b))**

☐ Check here if this section does not apply to your state.

4.4. Describe the procedures that assure that:

4.4.1. Through the screening procedures used at intake and follow-up eligibility determination, including any periodic redetermination, that only targeted low-income children who are ineligible for Medicaid or not covered under a group health plan or health insurance coverage (including access to a state health benefits plan) are furnished child health assistance under the state child health plan. **(Sections 2102(b)(3)(A) and 2110(b)(2)(B)) (42 CFR 457.310(b) (42CFR 457.350(a)(1)) 457.80(c)(3))**

4.4.2. The Medicaid application and enrollment process is initiated and facilitated for children found through the screening to be potentially eligible for medical assistance under the state Medicaid plan under Title XIX. **(Section 2102)(b)(3)(B)) (42CFR 457.350(a)(2))**

4.4.3. The State is taking steps to assist in the enrollment in SCHIP of children determined ineligible for Medicaid. **(Sections 2102(a)(1) and (2) and 2102(c)(2)) (42CFR 431.636(b)(4))**

4.4.4. The insurance provided under the state child health plan does not substitute for coverage under group health plans. Check the appropriate box. **(Section 2102)(b)(3)(C)) (42CFR 457.805) (42 CFR 457.810(a)-(c))**

4.4.4.1. ☐ Coverage provided to children in families at or below 200% FPL: describe the methods of monitoring substitution.

4.4.4.2. ☐ Coverage provided to children in families over 200% and up to 250% FPL: describe how substitution is monitored and identify specific strategies to limit substitution if levels become unacceptable.

4.4.4.3. ☐ Coverage provided to children in families above 250% FPL: describe how substitution is monitored and identify specific strategies in place to prevent substitution.

4.4.4.4. ☐ If the state provides coverage under a premium assistance program, describe:

The minimum period without coverage under a group health plan, including any allowable exceptions to the waiting period.

The minimum employer contribution.

The cost-effectiveness determination.

4.4.5. Child health assistance is provided to targeted low-income children in the state who are American Indian and Alaska Native. **(Section 2102)(b)(3)(D)) (42 CFR 457.125(a))**

Section 5. Outreach (Section 2102(c))

Describe the procedures used by the state to accomplish:

Outreach to families of children likely to be eligible for child health assistance or other public or private health coverage to inform them of the availability of the programs, and to assist them in enrolling their children in such a program: **(Section 2102(c)(1)) (42CFR 457.90)**

Section 6. Coverage Requirements for Children's Health Insurance (Section 2103)

☐ **Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan,** and continue on to Section 7.

6.1. The state elects to provide the following forms of coverage to children: (Check all that apply.) **(42CFR 457.410(a))**

6.1.1. ☐ Benchmark coverage; **(Section 2103(a)(1) and 42 CFR 457.420)**

- 6.1.1.1. ☐ FEHBP-equivalent coverage; **(Section 2103(b)(1))** (If checked, attach copy of the plan.)
- 6.1.1.2. ☐ State employee coverage; **(Section 2103(b)(2))** (If checked, identify the plan and attach a copy of the benefits description.)
- 6.1.1.3. ☐ HMO with largest insured commercial enrollment **(Section 2103(b)(3))** (If checked, identify the plan and attach a copy of the benefits description.)

6.1.2. ☐ Benchmark-equivalent coverage; **(Section 2103(a)(2) and 42 CFR 457.430)** Specify the coverage, including the amount, scope and duration of each service, as well as any exclusions or limitations. Please attach a signed actuarial report that meets the requirements specified in 42 CFR 457.431. **See instructions.**

6.1.3. ☐ Existing Comprehensive State-Based Coverage; **(Section 2103(a)(3) and 42 CFR 457.440)** [Only applicable to New York; Florida; Pennsylvania] Please attach a description of the benefits package, administration, date of enactment. If existing comprehensive state-based coverage is modified, please provide an actuarial opinion documenting that the actuarial value of the modification is greater than the value as of 8/5/97 or one of the benchmark plans. Describe the fiscal year 1996 state expenditures for existing comprehensive state-based coverage.

6.1.4. ☐ Secretary-Approved Coverage. **(Section 2103(a)(4)) (42 CFR 457.450)**

- 6.1.4.1. ☐ Coverage the same as Medicaid State plan
- 6.1.4.2. ☐ Comprehensive coverage for children under a Medicaid Section 1115 demonstration project
- 6.1.4.3. ☐ Coverage that either includes the full EPSDT benefit or that the state has extended to the entire Medicaid population

6.1.4.4. ☐ Coverage that includes benchmark coverage plus additional

6.1.4.5. ☐ Coverage that is the same as defined by Aexisting comprehensive state-based coverage

6.1.4.6. ☐ Coverage under a group health plan that is substantially equivalent to or greater than benchmark coverage through a benefit by benefit comparison (Please provide a sample of how the comparison will be done)

6.1.4.7. ☐ Other (Describe)

6.2. The state elects to provide the following forms of coverage to children: (Check all that apply. If an item is checked, describe the coverage with respect to the amount, duration and scope of services covered, as well as any exclusions or limitations) **(Section 2110(a)) (42CFR 457.490)**

6.2.1. ☐ Inpatient services **(Section 2110(a)(1))**

6.2.2. ☐ Outpatient services **(Section 2110(a)(2))**

6.2.3. ☐ Physician services **(Section 2110(a)(3))**

6.2.4. ☐ Surgical services **(Section 2110(a)(4))**

6.2.5. ☐ Clinic services (including health center services) and other ambulatory health care services. **(Section 2110(a)(5))**

6.2.6. ☐ Prescription drugs **(Section 2110(a)(6))**

6.2.7. ☐ Over-the-counter medications **(Section 2110(a)(7))**

6.2.8. ☐ Laboratory and radiological services **(Section 2110(a)(8))**

6.2.9. ☐ Prenatal care and pre-pregnancy family services and supplies **(Section 2110(a)(9))**

6.2.10.☐ Inpatient mental health services, other than services described in 6.2.18., but including services furnished in a state-operated mental hospital and including residential or other 24-hour therapeutically planned structural services **(Section 2110(a)(10))**

6.2.11.☐ Outpatient mental health services, other than services described in 6.2.19, but including services furnished in a state-operated mental hospital and including community-based services **(Section 2110(a)(11)**

6.2.12.☐ Durable medical equipment and other medically-related or remedial devices (such as prosthetic devices, implants, eyeglasses, hearing aids, dental devices, and adaptive devices) **(Section 2110(a)(12))**

6.2.13.☐ Disposable medical supplies **(Section 2110(a)(13))**

6.2.14.☐ Home and community-based health care services (See instructions) **(Section 2110(a)(14))**

6.2.15.☐ Nursing care services (See instructions) **(Section 2110(a)(15))**

6.2.16.☐ Abortion only if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest **(Section 2110(a)(16)**

6.2.17.☐ Dental services **(Section 2110(a)(17))**

6.2.18.☐ Inpatient substance abuse treatment services and residential substance abuse treatment services **(Section 2110(a)(18))**

6.2.19.☐ Outpatient substance abuse treatment services **(Section 2110(a)(19))**

6.2.20.☐ Case management services **(Section 2110(a)(20))**

6.2.21.☐ Care coordination services **(Section 2110(a)(21))**

6.2.22.☐ Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders **(Section 2110(a)(22))**

6.2.23.☐ Hospice care **(Section 2110(a)(23))**

6.2.24.☐ Any other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic, or rehabilitative services. (See instructions) **(Section 2110(a)(24))**

6.2.25.☐ Premiums for private health care insurance **coverage** **(Section 2110(a)(25))**

6.2.26.☐ Medical transportation **(Section 2110(a)(26))**

6.2.27.☐ Enabling services (such as transportation, translation, and outreach services (See instructions) **(Section 2110(a)(27))**

6.2.28.☐ Any other health care services or items specified by the Secretary and not included under this section **(Section 2110(a)(28))**

6.3. The state assures that, with respect to pre-existing medical conditions, one of the following two statements applies to its plan: **(42CFR 457.480)**

6.3.1. ☐☐ The state shall not permit the imposition of any pre-existing medical condition exclusion for covered services **(Section 2102(b)(1)(B)(ii)); OR**

6.3.2. ☐ The state contracts with a group health plan or group health insurance coverage, or contracts with a group health plan to provide family coverage under a waiver (see Section 6.4.2. of the template). Pre-existing medical conditions are permitted to the extent allowed by HIPAA/ERISA **(Section 2103(f))**. Please describe: *Previously 8.6*

6.4. Additional Purchase Options. If the state wishes to provide services under the plan through cost effective alternatives or the purchase of family coverage, it must request the appropriate option. To be approved, the state must address the following: **(Section 2105(c)(2) and(3)) (42 CFR 457.1005 and 457.1010)**

6.4.1. ☐ **Cost Effective Coverage.** Payment may be made to a state in excess of the 10% limitation on use of funds for payments for: 1) other child health assistance for targeted low-income children; 2) expenditures for health services initiatives under the plan for improving

the health of children (including targeted low-income children and other low-income children); 3) expenditures for outreach activities as provided in section 2102(c)(1) under the plan; and 4) other reasonable costs incurred by the state to administer the plan, if it demonstrates the following **(42CFR 457.1005(a))**:

6.4.1.1. Coverage provided to targeted low-income children through such expenditures must meet the coverage requirements above; **Describe the coverage provided by the alternative delivery system**. **The state may cross reference section 6.2.1 - 6.2.28**. **(Section 2105(c)(2)(B)(i)) (42CFR 457.1005(b))**

6.4.1.2. The cost of such coverage must not be greater, on an average per child basis, than the cost of coverage that would otherwise be provided for the coverage described above.; **Describe the cost of such coverage on an average per child basis**. **(Section 2105(c)(2)(B)(ii)) (42CFR 457.1005(b))**

6.4.1.3. The coverage must be provided through the use of a community-based health delivery system, such as through contracts with health centers receiving funds under section 330 of the Public Health Service Act or with hospitals such as those that receive disproportionate share payment adjustments under section 1886(c)(5)(F) or 1923 of the Social Security Act. **Describe the community based delivery system**. **(Section 2105(c)(2)(B)(iii)) (42CFR 457.1005(a))**

6.4.2. ☐ **Purchase of Family Coverage.** Describe the plan to purchase family coverage. Payment may be made to a state for the purpose of family coverage under a group health plan or health insurance coverage that includes coverage of targeted low-income children, if it demonstrates the following: **(Section 2105(c)(3)) (42CFR 457.1010)**

6.4.2.1. Purchase of family coverage is cost-effective relative to the amounts that the state would have paid to obtain comparable coverage only of the targeted low-income children involved; and **(Describe the associated costs for purchasing the family coverage relative to the coverage for the low income children.)** **(Section 2105(c)(3)(A)) (42CFR 457.1010(a))**

6.4.2.2. The state assures that the family coverage would not otherwise substitute for health insurance coverage that would be provided to such children but for the purchase of family coverage. **(Section 2105(c)(3)(B)) (42CFR 457.1010(b))**

6.4.2.3. The state assures that the coverage for the family otherwise meets title XXI requirements**.** **(42CFR 457.1010(c))**

Section 7. Quality and Appropriateness of Care

☐ **Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan,** and continue on to Section 8.

7.1. Describe the methods (including external and internal monitoring) used to assure the quality and appropriateness of care, particularly with respect to well-baby **care, well-**child care, and immunizations provided under the plan. **(2102(a)(7)(A)) (42CFR 457.495(a))**

Will the state utilize any of the following tools to assure quality?
(Check all that apply and describe the activities for any categories utilized.)

7.1.1. ☐ Quality standards
7.1.2. ☐ Performance measurement
7.1.3. ☐ Information strategies
7.1.4. ☐ Quality improvement strategies

7.2. Describe the methods used, including monitoring, to assure: **(2102(a)(7)(B)) (42CFR 457.495)**

7.2.1. Access to well-baby care, well-child care, well-adolescent care and childhood and adolescent immunizations. **(Section 2102(a)(7)) (42CFR 457.495(a))**

7.2.2. Access to covered services, including emergency services as defined in 42 CFR 457.10. **(Section 2102(a)(7)) 42CFR 457.495(b))**

7.2.3. Appropriate and timely procedures to monitor and treat enrollees with chronic, complex, or serious medical conditions, including access to an adequate number of visits to specialists experienced in treating the specific medical condition and access to out-of-network providers when the network is not adequate for the enrollee's medical condition. **(Section 2102(a)(7)) (42CFR 457.495(c))**

7.2.4. Decisions related to the prior authorization of health services are completed in accordance with state law or, in accordance with the medical needs of the patient, within 14 days after the receipt of a request for services. **(Section 2102(a)(7)) (42CFR 457.495(d))**

Section 8. Cost Sharing and Payment **(Section 2103(e))**

☐ **Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan,** and continue on to Section 9.

8.1. Is cost-sharing imposed on any of the children covered under the plan? **(42CFR 457.505)**

8.1.1. ☐ YES
8.1.2. ☐ NO, **skip to question 8.8.**

8.2. Describe the amount of cost-sharing, any sliding scale based on income, the group or groups of enrollees that may be subject to the charge and the service for which the charge is imposed or time period for the charge, as appropriate.
(Section 2103(e)(1)(A)) (42CFR 457.505(a), 457.510(b) &(c), 457.515(a)&(c))

8.2.1. Premiums:
8.2.2. Deductibles:
8.2.3. Coinsurance or copayments:
8.2.4. Other:

8.3. Describe how the public will be notified, including the public schedule, of this cost-sharing (including the cumulative maximum) and changes to these amounts and any differences based on income. **(Section 2103(e)((1)(B)) (42CFR 457.505(b))**

8.4. The state assures that it has made the following findings with respect to the cost sharing in its plan: **(Section 2103(e))**

8.4.1. ☐ Cost-sharing does not favor children from higher income families over lower income families. **(Section 2103(e)(1)(B)) (42CFR 457.530)**
8.4.2. ☐ No cost-sharing applies to well-baby and well-child care, including age-appropriate immunizations**.** **(Section 2103(e)(2)) (42CFR 457.520)**
8.4.3. ☐ No additional cost-sharing applies to the costs of emergency medical services delivered outside the network. **(Section 2103(e)(1)(A)) (42CFR 457.515(f))**

8.5. Describe how the state will ensure that the annual aggregate cost-sharing for a family does not exceed 5 percent of such family's income for the length of the child's eligibility period in the State. Include a description of the procedures that do not primarily rely on a refund given by the state for overpayment by an enrollee: **(Section 2103(e)(3)(B)) (42CFR 457.560(b) and 457.505(e))**

8.6 Describe the procedures the state will use to ensure American Indian (as defined by the Indian Health Care Improvement Act of 1976) and Alaska Native children will be excluded from cost-sharing. **(Section 2103(b)(3)(D)) (42CFR 457.535)**

8.7 Please provide a description of the consequences for an enrollee or applicant who does not pay a charge. **(42CFR 457.570 and 457.505(c))**

8.7.1 Please provide an assurance that the following disenrollment protections are being applied:

- ☐ State has established a process that gives enrollees reasonable notice of and an opportunity to pay past due premiums, copayments, coinsurance, deductibles or similar fees prior to disenrollment. **(42CFR 457.570(a))**
- ☐ The disenrollment process affords the enrollee an opportunity to show that the enrollee's family income has declined prior to disenrollment for non payment of cost-sharing charges. **(42CFR 457.570(b))**
- ☐ In the instance mentioned above, that the state will facilitate enrolling the child in Medicaid or adjust the child's cost-sharing Category as appropriate. **(42CFR 457.570(b))**
- ☐ The state provides the enrollee with an opportunity for an impartial review to address disenrollment from the program. **(42CFR 457.570(c))**

8.8 The state assures that it has made the following findings with respect to the payment aspects of its plan: **(Section 2103(e))**

8.8.1. ☐ No Federal funds will be used toward state matching requirements. **(Section 2105(c)(4)) (42CFR 457.220)**

8.8.2. ☐ No cost-sharing (including premiums, deductibles, copays, coinsurance and all other types) will be used toward state matching requirements**.** **(Section 2105(c)(5) (42CFR 457.224**) (*Previously 8.4.5)*

8.8.3. ☐ No funds under this title will be used for coverage if a private insurer would have been obligated to provide such assistance except for a provision limiting this obligation because the child is eligible under the this title. **(Section 2105(c)(6)(A)) (42CFR 457.626(a)(1))**

8.8.4. ☐ Income and resource standards and methodologies for determining Medicaid eligibility are not more restrictive than those applied as of June 1, 1997. **(Section 2105(d)(1)) (42CFR 457.622(b)(5))**

8.8.5. ☐ No funds provided under this title or coverage funded by this title will include coverage of abortion except if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest. **(Section 2105)(c)(7)(B)) (42CFR 457.475)**

8.8.6. ☐ No funds provided under this title will be used to pay for any abortion or to assist in the purchase, in whole or in part, for coverage

that includes abortion (except as described above). **(Section 2105)(c)(7)(A)) (42CFR 457.475)**

The California Managed Risk Medical Insurance Board
1000 G Street, Suite 450
Sacramento, CA 95814
(916) 324-4695 FAX: (916) 324-4878

Section 9. Strategic Objectives and Performance Goals and Plan Administration (Section 2107)

9.1. Describe strategic objectives for increasing the extent of creditable health coverage among targeted low-income children and other low-income children: **(Section 2107(a)(2)) (42CFR 457.710(b))**

9.2. Specify one or more performance goals for each strategic objective identified: **(Section 2107(a)(3)) (42CFR 457.710(c))**

9.3. Describe how performance under the plan will be measured through objective, independently verifiable means and compared against performance goals in order to determine the state's performance, taking into account suggested performance indicators as specified below or other indicators the state develops**:** **(Section 2107(a)(4)(A),(B)) (42CFR 457.710(d))**

Check the applicable suggested performance measurements listed below that the state plans to use: **(Section 2107(a)(4))**

- 9.3.1. ☐ The increase in the percentage of Medicaid-eligible children enrolled in Medicaid.
- 9.3.2. ☐ The reduction in the percentage of uninsured children.
- 9.3.3. ☐ The increase in the percentage of children with a usual source of care.
- 9.3.4. ☐ The extent to which outcome measures show progress on one or more of the health problems identified by the state.
- 9.3.5. ☐ HEDIS Measurement Set relevant to children and adolescents younger than 19.
- 9.3.6. ☐ Other child appropriate measurement set. List or describe the set used.
- 9.3.7. ☐ If not utilizing the entire HEDIS Measurement Set, specify which measures will be collected, such as:
  - 9.3.7.1. ☐ Immunizations
  - 9.3.7.2. ☐ Well child care
  - 9.3.7.3. ☐ Adolescent well visits
  - 9.3.7.4. ☐ Satisfaction with care
  - 9.3.7.5. ☐ Mental health
  - 9.3.7.6. ☐ Dental care
  - 9.3.7.7. ☐ Other, please list:
- 9.3.8. ☐ Performance measures for special targeted populations.

9.4. ☐ The state assures it will collect all data, maintain records and furnish reports to the Secretary at the times and in the standardized format that the Secretary requires.**(Section 2107(b)(1)) (42CFR 457.720)**

9.5. ☐ The state assures it will comply with the annual assessment and evaluation required under Section 10. Briefly describe the state's plan for these annual assessments and reports. **(Section 2107(b)(2)) (42CFR 457.750)**

9.6. ☐ The state assures it will provide the Secretary with access to any records or information relating to the plan for purposes of review of audit. **(Section 2107(b)(3)) (42CFR 457.720)**

9.7. ☐ The state assures that, in developing performance measures, it will modify those measures to meet national requirements when such requirements are developed. **(42CFR 457.710(e))**

9.8. The state assures, to the extent they apply, that the following provisions of the Social Security Act will apply under Title XXI, to the same extent they apply to a state under Title XIX: **(Section 2107(e)) (42CFR 457.135)**

9.8.1. ☐ Section 1902(a)(4)(C) (relating to conflict of interest standards)
9.8.2. ☐ Paragraphs (2), (16) and (17) of Section 1903(i) (relating to limitations on payment)
9.8.3. ☐ Section 1903(w) (relating to limitations on provider donations and taxes)
9.8.4. ☐ Section 1132 (relating to periods within which claims must be filed)

9.9. Describe the process used by the state to accomplish involvement of the public in the design and implementation of the plan and the method for insuring ongoing public involvement. **(Section 2107(c)) (42CFR 457.120(a) and (b))**

9.9.1 Describe the process used by the state to ensure interaction with Indian Tribes and organizations in the state on the development and implementation of the procedures required in 42 CFR 457.125. **Section 2107(c)) (42CFR 457.120(c))**

9.9.2 For an amendment relating to eligibility or benefits (including cost sharing and enrollment procedures), please describe how and when prior public notice was provided as required in 457.65(b) through (d).

9.10. Provide a one year projected budget. A suggested financial form for the budget is attached. The budget must describe: **(Section 2107(d)) (42CFR 457.140)**

- Planned use of funds, including --
  - Projected amount to be spent on health services;

- Projected amount to be spent on administrative costs, such as outreach, child health initiatives, and evaluation; and
- Assumptions on which the budget is based, including cost per child and expected enrollment.

- Projected sources of non-Federal plan expenditures, including any requirements for cost-sharing by enrollees.

Section 10. Annual Reports and Evaluations (Section 2108)

10.1. Annual Reports. The state assures that it will assess the operation of the state plan under this Title in each fiscal year, including: **(Section 2108(a)(1),(2)) (42CFR 457.750)**

10.1.1. ☐ The progress made in reducing the number of uncovered low-income children and report to the Secretary by January 1 following the end of the fiscal year on the result of the assessment, and

10.2. ☐ The state assures it will comply with future reporting requirements as they are developed. **(42CFR 457.710(e))**

10.3. ☐ The state assures that it will comply with all applicable Federal laws and regulations, including but not limited to Federal grant requirements and Federal reporting requirements.

ENCLOSURE 14

Assembly Bill 495, Diaz, Chapter 648, Statutes of 2001

BILL NUMBER: AB 495CHAPTERED
BILL TEXT

CHAPTER 648
FILED WITH SECRETARY OF STATE OCTOBER 10, 2001
APPROVED BY GOVERNOR OCTOBER 9, 2001
PASSED THE ASSEMBLY SEPTEMBER 14, 2001
PASSED THE SENATE SEPTEMBER 13, 2001
AMENDED IN SENATE SEPTEMBER 7, 2001
AMENDED IN SENATE AUGUST 31, 2001
AMENDED IN SENATE AUGUST 20, 2001
AMENDED IN SENATE JULY 17, 2001
AMENDED IN SENATE JULY 9, 2001
AMENDED IN SENATE JULY 3, 2001
AMENDED IN ASSEMBLY JUNE 4, 2001
AMENDED IN ASSEMBLY APRIL 26, 2001
AMENDED IN ASSEMBLY APRIL 5, 2001

INTRODUCED BY Assembly Members Diaz and Cohn
(Coauthors: Assembly Members Alquist, Calderon, Canciamilla, Cardenas, Cedillo, Chan, Chavez, Correa, Firebaugh, Florez, Frommer, Goldberg, Havice, Horton, Koretz, Liu, Longville, Lowenthal, Nakano, Negrete McLeod, Oropeza, Papan, Reyes, Salinas, Shelley, Simitian, Steinberg, Vargas, Wayne, Wesson, and Wiggins)
(Coauthors: Senators Figueroa, Kuehl, Ortiz, Polanco, Romero, Soto, and Vasconcellos)

FEBRUARY 21, 2001

An act to add Part 6.4 (commencing with Section 12699.50) to Division 2 of the Insurance Code, relating to health care coverage, and declaring the urgency thereof, to take effect immediately.

LEGISLATIVE COUNSEL'S DIGEST

AB 495, Diaz. Health care coverage.

Existing law provides for health care coverage for children in low-income households through the Healthy Families Program and for the provision of health benefits to qualifying individuals through Medi-Cal. Existing law also provides for services for handicapped persons under 21 years of age pursuant to the California Children's

Services Program. Under existing law, a county may organize a prepaid health plan, which is designated as a local initiative, to provide health care to eligible Medi-Cal beneficiaries.

This bill would create the Children's Health Initiative Matching Fund in the State Treasury, which would be administered by the Managed Risk Medical Insurance Board, in collaboration with the State Department of Health Services, for the purpose of providing matching state funds and local funds received by the fund through intergovernmental transfers to a county agency, a local initiative, or a county organized health system to provide health insurance coverage to certain children in low-income households who do not qualify for health care benefits through the Healthy Families Program or Medi-Cal. The bill would also provide for the referral of eligible children to the California Children's Services Program, as specified.

This bill would declare that it is to take effect immediately as an urgency statute.

THE PEOPLE OF THE STATE OF CALIFORNIA DO ENACT AS FOLLOWS:

SECTION 1. Part 6.4 (commencing with Section 12699.50) is added to Division 2 of the Insurance Code, to read:

PART 6.4. CHILDREN'S HEALTH INITIATIVE MATCHING FUND

12699.50. This part shall be known and may be cited as the Children's Health Initiative Matching Fund.

12699.51. For the purposes of this part, the following definitions shall apply:

(a) "Administrative costs" means those expenses that are not incurred for the direct provision of health benefits.

(b) "Applicant" means a county agency, a local initiative, or a county organized health system.

(c) "Board" means the Managed Risk Medical Insurance Board.

(d) "Child" means a person under 19 years of age.

(e) "Comprehensive health insurance coverage" means the coverage described in Section 12693.60.

(f) "County organized health system" means a health system

implemented pursuant to Article 2.8 (commencing with Section 14087.5)
of Chapter 7 of Part 3 of Division 9 of the Welfare and Institutions
Code and Article 1 (commencing with Section 101675) of Chapter 3 of
Part 4 of Division 101 of the Health and Safety Code.

(g) "Fund" means the Children's Health Initiative Matching Fund.

(h) "Local initiative" has the same meaning as set forth in Section 12693.08.

12699.52. (a) The Children's Health Initiative Matching Fund is
hereby established within the State Treasury. The fund shall accept
intergovernmental transfers as the nonfederal matching fund
requirement for federal financial participation through the State
Children's Health Insurance Program (Subchapter 21 (commencing with
Section 1397aa) of Chapter 7 of Title 42 of the United States Code).

(b) The board shall administer this fund and the provisions of this part in collaboration with the State Department of Health Services for the express purpose of allowing local funds to be used
to facilitate increasing the state's ability to utilize federal funds
available to California. These federal funds shall be used prior to
the expiration of their authority for one-time programs designed to
improve and expand access for uninsured persons.

12699.53. (a) An applicant that will provide an intergovernmental
transfer may submit a proposal to the board for funding for the
purpose of providing comprehensive health insurance coverage to any
child who meets citizenship and immigration status requirements that
are applicable to persons participating in the program established by
Title XXI of the Social Security Act, except as specified in Section
12693.76, whose family income is at or below 300 percent of the federal poverty level in specific geographic areas, as published quarterly in the Federal Register by the Department of Health and Human Services, and who does not qualify for either the Healthy Families Program (Part 6.2 (commencing with Section 12693) or the Medi-Cal Act (Chapter 7 (commencing with Section 14000) of Part 3 of

Division 9 of the Welfare and Institutions Code). The proposal shall guarantee at least one year of intergovernmental transfer funding by the applicant at a level that ensures compliance with the requirements of an approved federal waiver and shall, on an annual basis, either commit to fully funding the necessary intergovernmental amount to meet the conditions of the waiver or withdraw from the program. The board may identify specific geographical areas that, in comparison to the national level, have a higher cost of living or housing or a greater need for additional health services, using data obtained from the most recent federal census, the federal Consumer Expenditure Survey, or from other sources. The proposal may include an administrative mechanism for outreach and eligibility.

(b) The applicant may include in its proposal reimbursement of medical, dental, vision, or mental health services delivered to children who are eligible under the State Children's Health Insurance Program (Subchapter 21 (commencing with Section 1397aa) of Chapter 7 of Title 42 of the United States Code), if these services are part of an overall program with the measurable goal of enrolling served children in the Healthy Families Program.

(c) If a child is determined to be eligible for benefits for the treatment of an eligible medical condition under the California Children's Services Program pursuant to Article 5 (commencing with Section 123800) of Chapter 3 of Part 2 of Division 106 of the Health and Safety Code, the applicant shall not be responsible for the provision of, or payment for, those authorized services for that child. The proposal from an applicant shall contain provisions to ensure that a child whom the applicant reasonably believes would be eligible for services under the California Children's Services Program is referred to that program. The California Children's Services Program shall provide case management and authorization of services if the child is found to be eligible for the California Children's Services Program. Diagnosis and treatment services that

are authorized by the California Children's Services Program shall be performed by paneled providers for that program and approved special care centers of that program and approved by the California Children's Services Program. All other services provided under the proposal from the applicant shall be made available pursuant to this part to a child who is eligible for services under the California Children's Services Program.

12699.54. (a) The board and the State Department of Health Services, in consultation with participating entities, including the Healthy Families Advisory Committee, and other appropriate parties, shall establish the criteria for evaluating an applicant's proposal, which shall include, but not be limited to, the following:

(1) The extent to which the program described in the proposal provides comprehensive coverage including health, dental, and vision benefits.

(2) Whether the proposal includes a promotional component to notify the public of its provision of health insurance to eligible children.

(3) The simplicity of the proposal's procedures for applying to participate and for determining eligibility for participation in its program.

(4) The extent to which the proposal provides for coordination and conformity with benefits provided through Medi-Cal and the Healthy Families Program.

(5) The extent to which the proposal provides for coordination and conformity with existing Healthy Families Program administrative entities in order to prevent administrative duplication and fragmentation.

(6) The ability of the health care providers designated in the proposal to serve the eligible population and the extent to which the proposal includes traditional and safety net providers, as defined in regulations adopted pursuant to the Healthy Families Program.

(7) The extent to which the proposal intends to work with the

school districts and county offices of education.
(8) The total amount of funds available to the applicant to implement the program described in its proposal, and the percentage of this amount proposed for administrative costs as well as the cost to the state to administer the proposal.
(9) The extent to which the proposal seeks to minimize the substitution of private employer health insurance coverage for health benefits provided through a governmental source.
(10) The extent to which local resources may be available after the depletion of federal funds to continue any current program expansions for persons covered under local health care financing programs or for expanded benefits.
(b) The board, in collaboration with the State Department of Health Services, shall adopt regulations, setting forth the criteria it uses to evaluate an applicant's proposal.
12699.55. The board, in collaboration with the State Department of Health Services, shall review each funding proposal submitted by an applicant in accordance with the criteria described in Section 12699.54 and based on that criteria, approve or reject the proposal.

12699.56. (a) Upon its approval of a proposal, the board, in collaboration with the State Department of Health Services, may provide the applicant reimbursement in an amount equal to the amount that the applicant will contribute to implement the program described in its proposal, plus the appropriate and allowable amount of federal funds under the State Children's Health Insurance Program (Subchapter 21 (commencing with Section 1397aa) of Chapter 7 of Title 42 of the United States Code). Reimbursement provided from the Children's Health Initiative Matching Fund shall consist of intergovernmental transfers from applicants, as defined in subdivision (b) of Section 12699.51, and the appropriate and allowable federal State Children's Health Insurance Program funds.
Not more than 10 percent of the Childrens' Health Initiative Matching Fund shall be expended for administrative costs, including the costs to the state to administer the proposal. The board, in collaboration with the State Department of Health Services, may audit

the expenses incurred by the applicant in implementing its program to ensure that the expenditures comply with the provisions of this part. No reimbursement may be made to an applicant that fails to meet its financial participation obligation under this part. Reasonable start up costs and ongoing administrative costs for the program shall be reimbursed by those entities applying for funding.

(b) Each applicant that is provided funds under this part shall submit to the board a plan to limit initial and continuing enrollment in its program in the event the amount of moneys for its program is insufficient to maintain health insurance coverage for those participating in the program.

12699.57. Each health care service plan and specialized health care service plan that contracts to provide health care benefits under this part shall be licensed by the Department of Managed Health Care or be a county organized health system.

12699.58. The board, in collaboration with the State Department of Health Services, shall administer the provisions of this part and may do all of the following:

(a) Administer the expenditure of moneys from the fund.

(b) Adopt regulations, including the adoption of emergency regulations, in accordance with the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code).

12699.59. All expenses incurred by the board and the State Department of Health Services in administering the provisions of this part shall be paid from the fund.

12699.60. Nothing in this part creates a right or an entitlement to the provision of health insurance coverage or health care benefits. No costs shall accrue to the state for the provision of these services.

12699.61. The Governor, in collaboration with the Managed Risk Medical Insurance Board and the State Department of Health Services, shall apply for a waiver pursuant to the federal State Children's Health Insurance Program (Subchapter 21 (commencing with Section

1397aa) of Chapter 7 of Title 42 of the United States Code) in coordination with the Managed Risk Medical Insurance Board and the State Department of Health Services to allow a county agency, local initiative, or county organized health system to apply for matching funds through the federal State Children's Health Insurance Program (Subchapter 21 (commencing with Section 1397aa) of Chapter 7 of Title 42 of the United States Code) using local funds for the state matching funds.

12699.62. (a) The provisions of this part shall be implemented only if all of the following conditions are met:

(1) Federal funds are appropriated for this purpose.

(2) Federal participation is approved.

(3) The Managed Risk Medical Insurance Board determines that federal State Children's Health Insurance Program funds will remain available in the relevant fiscal year after providing funds for the following groups:

(A) All current enrollees and eligible children and parents that are likely to enroll in the Healthy Families Program in that fiscal year, as determined by a Department of Finance estimate.

(B) Rollover funds are determined to be available from the State Children's Health Insurance Program. For this purpose, "rollover funds" are those funds that are available on a one-time only basis through the federal State Children's Health Insurance Program (Subchapter 21 (commencing with Section 1397aa) of Chapter 7 of Title 42 of the United States Code) and are not committed for use by those groups described in subparagraph (A).

(b) The State Department of Health Services and the Managed Risk Medical Insurance Board may accept funding necessary for the preparation of the federal waiver application described in Section 12699.61 from a not-for-profit group or foundation.

(c) The submission and approval of federal waivers for State Children's Health Insurance Program funds that use state General Fund moneys for the addition of children or parents shall take precedence

over the submittal of the waiver required by Section 12699.61.

12699.63. The state shall be held harmless for any federal disallowance resulting from this part. An applicant receiving supplemental reimbursement pursuant to this part shall be liable for any reduced federal financial participation resulting from the implementation of this part with respect to that applicant. The state may recoup any federal disallowance from the applicant.

SEC. 2. This act is an urgency statute necessary for the immediate preservation of the public peace, health, or safety within the meaning of Article IV of the Constitution and shall go into immediate effect. The facts constituting the necessity are:

In order to expand the availability of insurance coverage for children in low-income households and to make available funding for that purpose as soon as possible, it is necessary that this act take effect immediately.

ENCLOSURE 15

Assembly Bill 1130, Diaz, Chapter 687, Statutes of 2003

BILL NUMBER: AB 1130 CHAPTERED
BILL TEXT

CHAPTER 687
FILED WITH SECRETARY OF STATE OCTOBER 9, 2003
APPROVED BY GOVERNOR OCTOBER 8, 2003
PASSED THE SENATE SEPTEMBER 13, 2003
PASSED THE ASSEMBLY SEPTEMBER 13, 2003
AMENDED IN SENATE SEPTEMBER 13, 2003
AMENDED IN SENATE SEPTEMBER 8, 2003
AMENDED IN SENATE AUGUST 21, 2003
AMENDED IN SENATE JULY 9, 2003
AMENDED IN ASSEMBLY MAY 7, 2003
AMENDED IN ASSEMBLY APRIL 22, 2003

INTRODUCED BY Assembly Member Diaz

FEBRUARY 21, 2003

An act to amend Section 12699.62 of, and to add Section 12699.525 to, the Insurance Code, relating to health care coverage, and making an appropriation therefore.

LEGISLATIVE COUNSEL'S DIGEST

AB 1130, Diaz. Health care coverage: Children's Health Initiative Matching Fund.

Existing law creates the Children's Health Initiative Matching Fund in the State Treasury, which is administered by the Managed Risk Medical Insurance Board, in collaboration with the State Department of Health Services, for the purpose of providing matching state funds and local funds received by the fund through intergovernmental transfers to a county agency, a local initiative, or a county organized health system to provide health insurance coverage to certain children in low-income households who do not qualify for health care benefits through the Healthy Families Program or Medi-Cal.

This bill would appropriate from the Federal Trust, for the 2002-03 fiscal year, a specified sum to the board that would be available for encumbrance for the purposes of these provisions. The bill would make related changes.

Appropriation: yes.

THE PEOPLE OF THE STATE OF CALIFORNIA DO ENACT AS FOLLOWS:

SECTION 1. Section 12699.525 is added to the Insurance Code, to read:

12699.525. The sum of eighty-nine million dollars ($89,000,000) is hereby appropriated in the 2002-03 fiscal year from the fund, and the sum of one hundred sixty-four million dollars ($164,000,000) is hereby appropriated for the 2002-03 fiscal year from the Federal Trust Fund, to the board and shall be available for encumbrance through June 30, 2004, for the purposes of this part.

SEC. 2. Section 12699.62 of the Insurance Code is amended to read:

12699.62. (a) The provisions of this part shall be implemented only if all of the following conditions are met:

(1) Federal financial participation is available for this purpose.

(2) Federal financial participation is approved.

(3) The Managed Risk Medical Insurance Board determines that the federal State Children's Health Insurance Program (Subchapter 21 (commencing with Section 1397aa) of Chapter 7 of Title 42 of the United States Code) funds remain available after providing funds for all current enrollees and eligible children and parents that are likely to enroll in the Healthy Families Program and, to the extent funded through the federal State Children's Health Insurance Program, the Access for Infants and Mothers Program and Medi-Cal program, as determined by a Department of Finance estimate.

(4) Funds are appropriated specifically for this purpose.

(b) The State Department of Health Services and the Managed Risk Medical Insurance Board may accept funding necessary for the preparation of the federal waiver applications or state plan amendments described in Section 12699.61 from a not-for-profit group or foundation

ENCLOSURE 16

State of California Certificate of Compliance

CCC-304

CERTIFICATION

I, the official named below, CERTIFY UNDER PENALTY OF PERJURY that I am duly authorized to legally bind the prospective Contractor to the clause(s) listed below. This certification is made under the laws of the State of California.

Contractor/Bidder Firm Name (Printed)	*Federal ID Number*
By (Authorized Signature)	
Printed Name and Title of Person Signing	
Date Executed	*Executed in the County of*

CONTRACTOR CERTIFICATION CLAUSES

1. STATEMENT OF COMPLIANCE: Contractor has, unless exempted, complied with the nondiscrimination program requirements. (GC 12990 (a-f) and CCR, Title 2, Section 8103) (Not applicable to public entities.)

2. DRUG-FREE WORKPLACE REQUIREMENTS: Contractor will comply with the requirements of the Drug-Free Workplace Act of 1990 and will provide a drug-free workplace by taking the following actions:

a. Publish a statement notifying employees that unlawful manufacture, distribution, dispensation, possession or use of a controlled substance is prohibited and specifying actions to be taken against employees for violations.

b. Establish a Drug-Free Awareness Program to inform employees about:

1) the dangers of drug abuse in the workplace;
2) the person's or organization's policy of maintaining a drug-free workplace;
3) any available counseling, rehabilitation and employee assistance programs; and,
4) penalties that may be imposed upon employees for drug abuse violations.

c. Every employee who works on the proposed Agreement will:

1) receive a copy of the company's drug-free workplace policy statement; and,
2) agree to abide by the terms of the company's statement as a condition of employment on the Agreement.

Failure to comply with these requirements may result in suspension of payments under the Agreement or termination of the Agreement or both and Contractor may be ineligible for award of any future State agreements if the department determines that any of the following has occurred: the Contractor has made false certification, or violated the certification by failing to carry out the requirements as noted above. (GC 8350 et seq.)

3. NATIONAL LABOR RELATIONS BOARD CERTIFICATION: Contractor certifies that no more than one (1) final unappealable finding of contempt of court by a Federal court has been issued against Contractor within the immediately preceding two-year period because of Contractor's failure to comply with an order of a Federal court, which orders Contractor to comply with an order of the National Labor Relations Board. (PCC 10296) (Not applicable to public entities.)

4. UNION ORGANIZING: Contractor hereby certifies that no request for reimbursement, or payment under this agreement, will seek reimbursement for costs incurred to assist, promote or deter union organizing.

5. CONTRACTS FOR LEGAL SERVICES $50,000 OR MORE- PRO BONO REQUIREMENT: Contractor hereby certifies that contractor will comply with the requirements of Section 6072 of the Business and Professions Code, effective January 1, 2003.

Contractor agrees to make a good faith effort to provide a minimum number of hours of pro bono legal services during each year of the contract equal to the lessor of 30 multiplied by the number of full time attorneys in the firm's offices in the State, with the number of hours prorated on an actual day basis for any contract period of less than a full year or 10% of its contract with the State.

Failure to make a good faith effort may be cause for non-renewal of a state contract for legal services, and may be taken into account when determining the award of future contracts with the State for legal services.

6. EXPATRIATE CORPORATIONS: Contractor hereby declares that it is not an expatriate corporation or subsidiary of an expatriate corporation within the meaning of Public Contract Code Section 10286 and 10286.1, and is eligible to contract with the State of California.

7. SWEATFREE CODE OF CONDUCT:

a. All Contractors contracting for the procurement or laundering of apparel, garments or corresponding accessories, or the procurement of equipment, materials, or supplies, other than procurement related to a public works contract, declare under penalty of perjury that no apparel, garments or corresponding accessories, equipment, materials, or supplies furnished to the state pursuant to the contract have been laundered or produced in whole or in part by sweatshop labor, forced labor, convict labor, indentured labor under penal sanction, abusive forms of child labor or exploitation of children in sweatshop labor, or with the benefit of sweatshop labor, forced labor, convict labor, indentured labor under penal sanction, abusive forms of child labor or exploitation of children in sweatshop labor. The contractor further declares under penalty of perjury that they adhere to the Sweatfree Code of Conduct as set forth on the California Department of Industrial Relations website located at www.dir.ca.gov, and Public Contract Code Section 6108.

b. The contractor agrees to cooperate fully in providing reasonable access to the contractor's records, documents, agents or employees, or premises if reasonably required by authorized officials of the contracting agency, the Department of Industrial Relations, or the Department of Justice to determine the contractor's compliance with the requirements under paragraph (a).

8. DOMESTIC PARTNERS: Commencing on July 1, 2004 Contractor certifies that it is in compliance with Public Contract Code section 10295.3 with regard to benefits for domestic partners. For any contracts executed or amended, bid packages advertised or made available, or sealed bids received on or after July 1 2004 and prior to January 1, 2007, a contractor may require an employee to pay the costs of providing additional benefits that are offered to comply with PCC 10295.3.

DOING BUSINESS WITH THE STATE OF CALIFORNIA

The following laws apply to persons or entities doing business with the State of California.

1. CONFLICT OF INTEREST: Contractor needs to be aware of the following provisions regarding current or former state employees. If Contractor has any questions on the status of any person rendering services or involved with the Agreement, the awarding agency must be contacted immediately for clarification.

Current State Employees (PCC 10410):

1). No officer or employee shall engage in any employment, activity or enterprise from which the officer or employee receives compensation or has a financial interest and which is sponsored or funded by any state agency, unless the employment, activity or enterprise is required as a condition of regular state employment.

2). No officer or employee shall contract on his or her own behalf as an independent contractor with any state agency to provide goods or services.

Former State Employees (PCC 10411):

1). For the two-year period from the date he or she left state employment, no former state officer or employee may enter into a contract in which he or she engaged in any of the negotiations, transactions, planning, arrangements or any part of the decision-making process relevant to the contract while employed in any capacity by any state agency.

2). For the twelve-month period from the date he or she left state employment, no former state officer or employee may enter into a contract with any state agency if he or she was employed by that state agency in a policy-making position in the same general subject area as the proposed contract within the 12-month period prior to his or her leaving state service.

If Contractor violates any provisions of above paragraphs, such action by Contractor shall render this Agreement void. (PCC 10420)

Members of boards and commissions are exempt from this section if they do not receive payment other than payment of each meeting of the board or commission, payment for preparatory time and payment for per diem. (PCC 10430 (e))

2. LABOR CODE/WORKERS' COMPENSATION: Contractor needs to be aware of the provisions which require every employer to be insured against liability for Worker's Compensation or to undertake self-insurance in accordance with the provisions, and Contractor affirms to comply with such provisions before commencing the performance of the work of this Agreement. (Labor Code Section 3700)

3. AMERICANS WITH DISABILITIES ACT: Contractor assures the State that it complies with the Americans with Disabilities Act (ADA) of 1990, which prohibits discrimination on the basis of disability, as well as all applicable regulations and guidelines issued pursuant to the ADA. (42 U.S.C. 12101 et seq.)

4. CONTRACTOR NAME CHANGE: An amendment is required to change the Contractor's name as listed on this Agreement. Upon receipt of legal documentation of the name change the State will process the amendment. Payment of invoices presented with a new name cannot be paid prior to approval of said amendment.

5. CORPORATE QUALIFICATIONS TO DO BUSINESS IN CALIFORNIA:

a. When agreements are to be performed in the state by corporations, the contracting agencies will be verifying that the contractor is currently qualified to do business in California in order to ensure that all obligations due to the state are fulfilled.

b. "Doing business" is defined in R&TC Section 23101 as actively engaging in any transaction for the purpose of financial or pecuniary gain or profit. Although there are some statutory exceptions to taxation, rarely will a corporate contractor performing within the state not be subject to the franchise tax.

c. Both domestic and foreign corporations (those incorporated outside of California) must be in good standing in order to be qualified to do business in California. Agencies will determine whether a corporation is in good standing by calling the Office of the Secretary of State.

6. RESOLUTION: A county, city, district, or other local public body must provide the State with a copy of a resolution, order, motion, or ordinance of the local governing body which by law has authority to enter into an agreement, authorizing execution of the agreement.

7. AIR OR WATER POLLUTION VIOLATION: Under the State laws, the Contractor shall not be*:* (1) in violation of any order or resolution not subject to review promulgated by the State Air Resources Board or an air pollution control district; (2) subject to cease and desist order not subject to review issued pursuant to Section 13301 of the Water Code for violation of waste discharge requirements or discharge prohibitions; or (3) finally determined to be in violation of provisions of federal law relating to air or water pollution.

8. PAYEE DATA RECORD FORM STD. 204: This form must be completed by all contractors that are not another state agency or other governmental entity.

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